REPUBLIC OF KENYA

COUNTY GOVERNMENT OF MOMBASA

TASK FORCE REPORT

ON MOMBASA COUNTY HEALTHCARE SYSTEM

JANUARY 2023

REPUBLIC OF KENYA

COUNTY GOVERNMENT OF MOMBASA

THE TASKFORCE BRIEFING MEETING WITH H.E. THE GOVERNOR ON 21ST DECEMBER 2022

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LIST OF **ABBREVIATIONS**

AIE	Authority to Incur Expenditure
ANC	Ante-Natal Clinic
ARV's	Anti-Retrovirals
BEOC	Basic Emergency Obstetric Care
BSN	Bachelor of Nursing
CCC	Comprehensive Care Centres
CCTVs	Closed Circuit Television
CDOH	County Department of Health
CDPH	County Director of Public Health
CECM(F)	County Executive Committee Member for Finance
CECM(H)	County Executive Committee Member for Health
CEO	Chief Executive Officer
CEOC	Comprehensive Emergency Obstetric Care
CG	County Government
CHA	Community Health Assistant
CHC	Community Health Committee
CHIS	Community Health Information System
CHMT	County Health Management Team
CHO	Community Health Officer
CHSSIP	County Health Sector Strategic and Investment Plan
CHU	Community Health Unit
CHVs	Community Health Volunteers
CIDP	County Integrated Development Plan
CME's	Continuous Medical Education
COG	Council of Governors
CO	Chief Officer
CoK	Constitution of Kenya
CPSB	County Public Service Board
CRA	Commission for Revenue Allocation
CSOs	Civil Society Organizations
CT	Computerized Tomography

DALY	Daily Adjusted Life Years
DANIDA	Danish International Development Agency
DHIS2	District Health Information System 2
DHP	Digital Health Platform
DHPT	Directorate of Health products and Technologies
EHR	Electronic Health Records
EHR	Electronic Health Records system
EMR	Electronic Medical Records
FBOs	Faith Based Organization
FIF	Facility Improvement Fund
FMC	Facility Management Committees
GBV	Gender Base Violence
GDP	Good Distribution Practice
GF	Global Financing Facility
GTS	Geospatial Technologies Services
HDU	High Dependency Unit
HFMT	Health Facility Management Team
HIS	Health Information System
HIV/AIDS	Human Immuno-Deficiency Virus/ Acquired Immune Deficiency Syndrome
HMIS	Health Management Information System
HMT	Hospital Management Teams
HPT	Health Products and Technologies
HR	Human Resource
HRD	Human Resource Development
HRH	Human Resources for Health
HRIS	Human Resources Information System
HRM	Hunan Resource Management
HRO	Human Resource Officer
ICT	Information Communication Technology
ICU	Intensive Care Unit
IFMIS	Integrated Financial Management Information System
ISO	International Standards Organization
KAIS	Kenya AIDS Indicator Survey

KDHS	Kenya Demographic Health Survey
KECHN	Kenya Enrolled Community Health Nurse
KEML	Kenya Essential Medicines List
KEMSA	Kenya Medical Supplies Authority
KEPH	Kenya Essential Package for Health
KES	Kenya Shillings
KHIS	Kenya Health Information System
KHP	Kenya Health Policy 2014-2030
KNBS	Kenya National Bureau of Statistics
KNH	Kenyatta National Hospital
KRCHN	Kenya Registered Community Health Nurse
KRN	Kenya Registered Nurse
KShs	Kenya Shillings
LMIS	Logistical Management Information System
M&E	Monitoring and Evaluation
MCH/FP	Maternal Child Health/ Family Planning
MEDS	Mission for Essential Drugs
MES	Managed Equipment Service
MHM	Menstrual Hygiene Management
MICS	Multiple Indicator Cluster Survey
MNCH	Maternal Neo-natal Child Health
MoH	Ministry of Health
MoU	Memorandum of Understanding
MRI	Magnetic Resonance Imaging
MSF	Medicines Sans Frontiers
NCDs	Non-Communicable Diseases
NGO	Non-Governmental Organization
NHIF	National Health Insurance Fund
NICU	Neo-natal Intensive Care Unit
OPD	Out Patient Department
OSH	Occupational Safety and Health Hazards
PHRO	Principal Human Resource Officer
PnP	Permanent and Pensionable

PPDA	Public Procurement and Asset Disposal Act
PPP	Public Private Partnership
PSC	Public Service Commission
RH	Reproductive Health Services
SCHMT	Sub-County Health Management Team
SDH	Social determinants of health
SOPs	Standard Operating Procedures
SRC	Salaries and Remuneration Commission
STIs	Sexually Transmitted infections
SWOT	Strengths Weaknesses Opportunities and Threats
TB	Tuberculosis
UHC	Universal Health Coverage
UN	United Nations
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
WASH	Water, Sanitation and Hygiene
WB	World Bank
WHO	World Health Organization
WIBA	Workman Injury Benefit Act

ACKNOWLEDGEMENTS

Foremost, I thank the Almighty God for His mercy and guidance to enable us deliver on this mandate. The development of the Mombasa County Government Healthcare System Task force Report was accomplished through the concerted efforts of various organizations, institutions, stakeholders and experts, who contributed in a variety of ways towards its preparation, editing and publication.

Secondly, I deeply thank His Excellency Governor Abdulswamad Shariff Nassir for entrusting members of the Task force with the onerous duty to fact-find the challenges and propose workable recommendations for the reform and improvement of the Mombasa County health system towards universal health coverage and the full enjoyment of the right to highest attainable standards of health and healthcare services by all Mombasa County residents.

Thirdly, I would like to thank most sincerely, Dr. Noah Akalla, the Chief of Staff and the Ag. County Secretary for the facilitation offered to the team in terms of meeting venues and logistics during the facility and benchmarking visits, public participation exercises and stakeholder engagements. Equally, I specially thank Dr. Khadija Soud Shikely, Chief Officer Medical Services, Ms. Pauline Oginga, Chief Officer, Public Health and Dr. Iqbal Khandwalla, the Chief Executive Officer, Coast General Teaching and Referral Hospital for their active participation as members of the Task force and for their unreserved commitment and support throughout the exercise. Special thanks goes to the Governor's Young Leaders' Program (GYLP) for their dedication and commitment to deliver on the mandate through the Task force Secretariat.

I extend much gratitude to all the stakeholders including the residents of Mombasa, healthcare workers, community health volunteers, county staff, the private sector, civil society organizations, labour organizations, National Health Insurance Fund, professional associations, development partners and political leaders including members of parliament and the Mombasa County Assembly among other stakeholders, for sparing time to offer their views and proposals freely and sincerely during the Task force stakeholder engagement and public hearing forums.

Further, the development of this Task force report would not have been made possible without the financial and technical support from Amref Health Africa in Kenya as well as the technical assistance of Dr. Charles Oyaya in the review, collation and analysis of the stakeholder views and information and the preparation of the Task force Report.

Finally, I highly appreciate the sheer commitment and hard work by all and each of the members of the Task force and the sub-committees to make this assignment a success.

Dr. Chibanzi Mwachonda | **Chairperson**

Mombasa County Healthcare System Task force

1. INTRODUCTION

The Mombasa County Healthcare System Task force was established by H.E. Governor Abdulswamad Shariff Nassir upon assuming office via Executive Order No.1 of 2022 on 22nd September 2022 and was formally gazetted vide the Kenya Gazette Notice No. 11740 dated 30th September 2022 to engage stakeholders to review and recommend reforms in the Mombasa County Healthcare System.

The Task force in discharge of its Mandate, recognized, His Excellency, the Governor's commitment to prioritizing interventions aimed at cushioning the most vulnerable in the society by ensuring the minimum standard of living and dignity for all and universal health coverage through the introduction of the Mombasa Care initiative in line with the Bill of Rights.

The Task force in discharging its duties reviewed existing literature on healthcare service delivery in the Kenya and the global context, adopted a highly engaging process with involvement and consultation with key health sector stakeholders from within and outside the County through benchmarking visits, conducting facility visits and engaging healthcare workers; public participation by engaging the community, political leaders, development partners, the private sector, and other organizations. Additionally, four subcommittees were constituted in line with the key thematic areas outlined in the Terms of Reference.

2. KEY FINDINGS AND RECOMMENDATIONS

Broadly, despite the general improvement in the health profile and indicators of the county over the last decade, Mombasa County still faces several health challenges including high burden of both communicable and non-communicable diseases such as HIV/AIDS, tuberculosis, upper respiratory tract infections, hypertension, diabetes, cancers and malnutrition as well as maternal, newborn and child mortality. This largely attributed to inadequate access to quality services linked to health system deficiencies such as inadequate health infrastructure and equipment, shortage of qualified and motivated staff, inadequate supply and distribution of health products, inadequate health information systems and utilization of data to inform decisions as well as limited investment in the health sector.

The key findings and recommendations of the Task force are presented around eight (8) thematic areas as follows:

a. The architecture of healthcare delivery
b. Physical healthcare infrastructure
c. Healthcare financing
d. Healthcare system supply chains
e. Human Resources for Health
f. Health Management Information system
g. Disease burden and disease patterns
h. Universal Health Coverage

2.1 The architecture of healthcare delivery

The Task force findings indicated functional overlaps, inadequate implementation and operationalization of policies and laws and largely dysfunctional service delivery at all levels despite significant efforts to re-organize and strengthen the health system, improve the policy and legal environment and to expand the physical access to healthcare services over the past years. The Task force therefore recommends:

a. Establishment of the Mombasa County Health Management Board.

b. A review of the Executive Order No.1 of June 2019 establishing CGTRH as a county corporation to ensure conformity to the Constitution and the applicable national and county legislation.

c. A Review of the Mombasa County Health Act, 2018 and the Mombasa County Environmental Health and Sanitation Act, 2017 to provide enabling framework for the implementation of the health system reform recommendations.

d. Operationalize and optimize all existing facilities to enhance operational efficiency and service delivery at various health system levels as per norms and standards.

e. The establishment of a well-structured independent emergency response Centre with adequate ambulances, call Centre, GPS tracking and manned by adequately trained personnel.

2.2 Physical healthcare infrastructure

The Task force conducted facility visits and evaluated the state of the healthcare facilities. It was a general finding that most of the public health facilities do not meet the required minimum standards for the provision of quality healthcare at the respective levels of service. The existing public health facilities are overstretched while many health facilities are in a dilapidated state with poorly maintained infrastructure and equipment. It was further observed that several development projects are either incomplete or stalled for various reasons including pending bills. Most health facilities are grappling with insecurity, including the security of tenure, with most health facilities lacking title deeds and perimeter fences, proper security lighting systems and CCTVs. The Task force therefore recommends:

a. Immediate review and clearance of all health sector pending bills to ensure the completion of all ongoing and/or stalled infrastructure development projects

b. Dispose of and replace obsolete equipment in all facilities as per the Public Procurement and Asset Disposal Act

c. Prioritize rehabilitation, renovation and maintenance of existing building infrastructure at all levels of care, giving priority to the old facilities with ageing and dilapidated buildings/infrastructure

d. Explore PPP Models for equipment leasing and routine laboratory examination as a backup and histopathology and sample referral

e. Prioritise the setting of Speciality Hospitals by upgrading and re-purposing some existing facilities into centres of excellence in the provision of specialty health services.

2.3 Healthcare financing

The Task force noted that the county heavily relies on development partners and catastrophic out-of-pocket expenditure by households to finance healthcare expenditure and programs with frequent delays in disbursement of monies from the national government, NHIF and county exchequer. Furthermore, the centralized on-budgeting system from the county exchequer is bureaucratic to access and fraught with delayed budget releases to finance sector activities leading to delays in payment of creditors leading to chronic stock out of health products and technologies. The Task force therefore recommends:

a. Develop a county business and financing model for county health services.
b. Establish County Health Services Fund to ring-fence funds appropriated for health services including grants to ensure sustainable financing of health functions.
c. Aggressive awareness creation and households' registrations to the NHIF scheme to be maximized through community health units and county administration structure
d. Remove unnecessary bureaucracy in the payment processing in the supply chain to restore confidence
e. Fully automate revenue collection to improve revenue collection and efficient service delivery.

2.4 Healthcare system supply chains

The Task force noted that the current practices of acquiring health products, technologies, and services involve centralized tendering systems. The overall picture that emerged is that the current supply chain management system for healthcare in Mombasa County is weak and characterized by many deficiencies regarding the transparency of the procurement of the processes, delays in payment of suppliers, pending bills, chronic stock-outs and lack of HPTs for prolonged periods of time. The Task force therefore recommends:

a. Strengthen governance structures for HPT at the County Department of Health (CDOH) for effective leadership and stewardship of the HPT pillar of the county health system
b. Clear Pending Bills with KEMSA to ensure timely access to HPTs
c. Establish a common HPT purchasing and warehousing system within Mombasa County leveraging on economies of scale
d. Regularize the process of Pre-qualification and update the List of pre-qualified Suppliers

2.5 Human resources for health

The Task force recognizes the fact that human resources are a key pillar of healthcare services delivery. However, this remains as one of the greatest challenges of the county health system. Issues of inadequate health workforce establishment, poor work environment and chronic delays in salary payment and remittance of statutory deductions and positions left vacant for a long period of time remain matters of grave concern. These have cumulatively resulted in a highly demotivated health workforce leading to poor service delivery. The Task force therefore recommends:

e. Conduct a comprehensive health workforce and work environment assessment
f. Review the current county HRH establishment and determine actual needs using workload analysis to guide recruitments, promotions, staff deployments and transfers.

g. Fill vacant positions promptly to ease the burden on the overstretched workforce that has led to inefficient service delivery.

h. Develop clear terms and conditions of services for the CHVs and consider regularizing the payment of CHVs stipend

i. Employ an automated performance tracking system for health workers.

j. Ensure timely payment of salaries and at the policy level determine processing and remittance time-lines.

k. Ensure wage bill sustainability and strengthen payroll management

l. Revive the Health Work Council to improve industrial harmony with trade unions by involving the union leaders in decisions affecting Healthcare Workers

2.6 Health Management Information system

The Task force recognizes the significance of a well-functioning health information system in ensuring effective service delivery, evidence-based decision making and functionality of the health system. Overall, the Mombasa County health information system remains weak and fragmented with data and information stored in many different formats across various systems and locations. This has made access, sharing, and analytics difficult or impossible to achieve and to support effective decision-making. The Task force therefore recommends:

a. Establish and operate a well-functioning integrated Mombasa County Health Information System and implement a county digital health transformation strategy

b. Increasing budget allocation for HMIS ensuring sustainable financing for HIS and Digital Health transformation.

c. Optimize the use of ICT and ensure infrastructure readiness: Setup a full ICT infrastructure in all the facilities and establish a central county data centre linked to primary and secondary data centres at the sub-county level.

d. Ensure adequate and skilled human resources for HIS and digital health including ICT personnel at county, sub-county and health facility levels.

2.7 Disease burden and disease patterns

The Task force recognizes the fact that despite some improvements in health indicators, the disease burden in Mombasa County is still unacceptably high yet the major causes of the disease burden, ill health and premature deaths can be prevented and controlled through simple cost-effective public health interventions. About 80% of all hospital attendance in Mombasa is attributed to preventable diseases and at least 50% of these preventable diseases are linked to poor water, sanitation and hygiene. The Task force recommends:

a. The prioritisation of, and increased budget allocation for public and environmental health to ensure effective prevention, management and control of the high burden of communicable, non-communicable and neo-natal diseases in the County.

b. Establishment of a special fund for public health surveillance programmes including research, epidemiological investigations or surveys of people, animals, or vectors

c. Establishment of CGTRH Utange Field Hospital to function as the County Infectious Diseases Hospital and Research Centre.

2.8 Achieving Universal Health Coverage

The Task force was cognizant of Kenya's UHC national initiative and the objective of Universal health coverage (UHC) being to ensure access to a full range and continuum of quality health services including promotive, preventive, curative, rehabilitative and palliative without financial hardship.

The UHC initiative presents an excellent opportunity for the County Government of Mombasa to accelerate the realization of the right of every person to the highest attainable standards of health and healthcare services and the full protection of the indigents and vulnerable individuals, families and populations from financial catastrophe or impoverishment associated with having to pay for the services. The Task force therefore recommends:

a. Establishment and implementation of the Mombasa Care program to enable all the residents, especially the indigents and vulnerable individuals and families to access affordable and quality healthcare services based on the Kenya Harmonized Health Benefits Package.
b. Automation of the HPT supply chain management system to reduce wastage and improve efficiency and accountability.
c. Increase County health budget to support UHC roll-out.

3. THE WAY FORWARD

The Task force recognizes His Excellency the Governor and his Government's commitment to implementing the recommendations contained in this report. The Task force therefore takes this opportunity to call upon all the stakeholders and partners for future engagements with the goal of implementing the recommendations put forth in this report. Your investment and collaboration in this regard will be of paramount importance in realizing the goal of attaining affordable and accessible universal health coverage in Mombasa County.

1.1 Introduction

His Excellency Abdullswamad Sheriff Nassir, the Governor of Mombasa County has pledged to have secure, well governed, competitive and sustainable county that contributes to the realization of the broader national development goals articulated in the Constitution of Kenya 2010 and Vision 2030. In his pledge, His Excellency the Governor has committed to prioritize interventions aimed at cushioning the most vulnerable in the society through social safety nets and ensuring the minimum standard of living and dignity for all the people of Mombasa County in line with the Bill of Rights.

On healthcare, H.E. the Governor committed to, among other things:

a. Resource the devolved healthcare infrastructure at sub-county level so that there is adequate staff, medication and equipment to serve the needs of the people;

b. Acquire a second cancer treatment machine and more dialysis machines to save the sick from traveling out of Mombasa for treatment and ensure people have access to quality oncology healthcare services;

c. Harmonize labour relations with healthcare workers to ensure that industrial actions become a thing of the past and that issues of recruitment, continuous and progressive training for healthcare workers and overdue promotions are resolved; and

d. Ensure Universal Healthcare for all through the introduction of the Mombasa Care initiative to ensure that all residents of Mombasa County are insured through the National Health Insurance Fund, giving priority to those citizens who cannot afford to pay for the insurance cover.

1.2 Appointment and Membership of the Task force

His Excellency Abdullswamad Sheriff Nassir, the Governor of Mombasa County on 22nd September, 2022 appointed the Mombasa County Health Care Systems Task force which was formally gazetted vide the Kenya Gazette Notice No. 11740 dated 30th September, 2022 to engage stakeholders to review and recommend reforms in the Mombasa County Health care system. The Task force comprised of the following members:

Dr. Chibanzi Mwachonda - **Chair**
Dr. Nassir Abdallah Shaaban - **Member**
Dr. Khadija Soud Shikely - **Member**
Dr. Ibrahim Matende - **Member**
Dr. Iqbal Khandwalla - **Member**
Dr. Noah Akala - **Member**
Ismael Ramadhan - **Member**
Pauline Oginga - **Member**
Emily Mursoi - **Member**
Margaret Damaris - **Member**
Mary Goye - **Member**
Silas Muthiani - **Member**
Siwatu Matano - **Member**
Rehema Juma - **Member**
Athman Kaginya - **Member**
Betty Sharon - **Member**

The Office of the Governor provided the secretariat support to the Task force. Backstopping assistance to the Task force by way of research, technical and logistical support was provided by the staff of the Mombasa County Government, consisting of the following:

Marwa Abdalla Mohamed - **Task force Secretariat**
Samuel Ochieng Oketch - **Task force Secretariat**
Faith Mumbua James - **Task force Secretariat**
Kinana Juma - **Governor's Office**
Pauline Mwami - **Governor's Office**
Simiyu Wekesa - **Governor's Office**
Abdalla Jaffar Idd - **Governor's Office**
Abdulrahman Omar - **Governor's Office**
Gloria Kendi - **Governor's Office**
Ali Boa Shalo - **Governor's Office**
Said Hussein - **Governor's Office**
Paul Tito - **Health Department**
Duncan Maghanga - **Health Department**
Nancy Mukui - **Health Department**
Ezra Oigara - **Health Department**
Kelvin Wafula - **Health Department**
Alvin Okumu - **Health Department**
Idris Peters - **Health Department**

1.3 The Mandate of the Task force

The mandate of the Task force gazetted vide Kenya Gazette Notice No. 11740 dated 30th September, 2022 was to engage stakeholders including but not limited to the general public, healthcare workers, the National Hospital Insurance Fund, to among others:-

a. Review the architecture of healthcare delivery including Human Resources for Health and ICT for Health in the County of Mombasa;
b. Assess the state of physical healthcare infrastructure including buildings and heavy and movable equipment in the County of Mombasa;
c. Audit the state of financing for healthcare in the County of Mombasa;
d. Evaluate the state of supply chains for healthcare in the county of Mombasa;
e. Recommend the upgrading and/or special purposing of existing medical facilities;
f. Audit public healthcare related human resource currently employed by the County Government and make recommendations on addressing the skills gap;
g. Assess and recommend the implementation of a comprehensive Health Management Information System for all County Government Hospitals;
h. Assess and recommend strategies on addressing disease patterns; and
i. Formulate lasting solutions towards achieving universal healthcare that is affordable and accessible in the County of Mombasa.

Based on the views expressed by aforementioned stakeholders including the general public, healthcare workers and the National Hospital Insurance Fund among others, the Task Force was required to prepare and submit its report to the Governor of Mombasa County together with its recommendations within the specified period.

1.4 The Task force Method of Work

The Taskforce work was guided by the principles and values of governance under Article 10 of the Constitution of Kenya 2010, which include participation of the people, the County Government Act No. 17 of 2012 and the County Public Participation Guidelines, 2016. The Taskforce therefore adopted a highly participatory and inclusive approach involving various stakeholders including individual residents, county staff including county treasury and procurement departments, healthcare workers, private sector, civil society organizations, labour organizations, National Health Insurance Fund, professional associations, development partners and political leaders including members of parliament and Mombasa County Assembly, among other stakeholders.

The information gathering involved literature review, town hall meetings, public forums, facility visits (34) benchmarking visits to KNH, Nakuru and MTRH and submission of memoranda. The Taskforce in collaboration with partners spent time and resources to stimulate participation, discussion and collection of public views. The Taskforce listened very carefully to the views of Mombasa residents and stakeholders throughout the county. The views and recommendation were collated, analysed, triangulated and presented in this report.

This Report was prepared by the Taskforce working through five thematic sub committees constituted as follows:

HRH and Infrastructure sub-committee

Dr. Khadija Shikely - **Chair & Taskforce member**
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Dr. Shem Patta - **Member**
Dr. Evelyne Sumbi - **Member**
Arch Simon Bwire - **Member**
Eng. James Wanyonyi - **Member**
John Kuti - **Member**
Ramadhan Dhida - **Member**
Dr. Samuel Muchemi - **Member**
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Rael Tinega - **Member**
Bahati Tineste - **Member**
Mariam Mbesa - **Member**
Mary Goye - **Member**
Suleiman Lugogo - **Member**

HMIS/EMR/ICT/Referral System sub-committee

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Emily Mursoi - **Member**
Esha Yahya - **Member**
Sarah Kayanda - **Member**
Amour Riyamy - **Member**
Victor Abayo - **Member**
Silas Kijanaa - **Member**
Margaret Damaris - **Member**
Ann Ndunge - **Secretariat**

Legal and Operation sub-committee

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Betty Sharon - **member**
Dr. Wanjiru Korir - **Member & Secretary**
Dr. Elizabeth Khisa - **Member**
Dr. Noah Akalla - **Member**
Jimmy Waliaula - **Member**
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Mohamed Masoud - **Member**
John Kuti - **Member**
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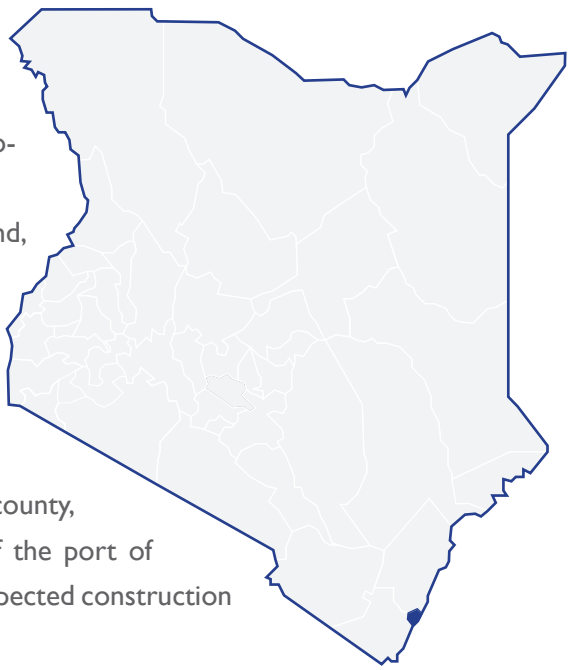
Faith Mumbua James - **Member**

2.1 Introduction

Mombasa County is in the South-Eastern part of the Coastal region of Kenya. It covers an area of 229.9Km² excluding 65Km² of water mass which is 200 nautical miles inside the Indian Ocean. It borders the Indian Ocean to the East and South East, Kilifi County to the North and Kwale to the West and South West. The County has the largest sea port, the Kilindini harbour, an international airport and serves as a major tourist attraction for both local and international tourists. The County also borders the Exclusive Economic Zone of the Indian Ocean to the East. Mombasa Island is connected to the Mainland in the South by Likoni Ferry, to the North by Nyali Bridge and to the West by Makupa Course Way.

2.2 Physical and Ecological conditions



The County lies within the coastal lowland which rises gradually from the sea level in the East to about 132m above sea level in the mainland. The terrain is characterized by three distinct physio-graphic features, which includes the coastal plain, found along the shoreline, covering parts of the South Coast, the Island, parts of Changamwe and the North Coast. The county's ecosystem has both marine and terrestrial components. The ecosystem is characterized by diverse species of flora and fauna, the most common being coconut trees and different species of fish, which have different cultural, social and financial values. The ecological conditions are evolving fast due to numerous developments in the county, including the recent dredging to deepen the Kilindini Channel of the port of Mombasa, construction of the second container terminal and the expected construction of the Mombasa City Southern by-pass (*Dongo-Kundu*).

The County lies within the hot tropical region where the climate is influenced by monsoon winds. The rainfall pattern is characterized by two distinct long and short seasons corresponding to changes in the monsoon winds. The long rains occur in April - June with an average of 1,040mm and correspond to the South Eastern Monsoon winds. The short rains start towards the end of October lasting until December and correspond to the comparatively dry North Eastern Monsoons, averaging 240mm. The annual average rainfall for the county is 640mm. The annual mean temperature in the county is 27.9°C with a minimum of 22.7°C and a maximum of 33.1°C. The hottest month is February with a maximum average of 33.1°C while the lowest temperature is in July with a minimum average of 22.7°C. Average humidity at noon is about 65%.

The County is experiencing increasing effects of climate change. Rainfall patterns have generally changed and are unpredictable. This has led to frequent flooding, high incidence of crop failure and on average, temperatures rise above normal in some instances, a situation not witnessed before. Due to the large and rapidly growing population, the County is also experiencing unprecedented environmental challenges including proliferation of illegal dump sites with piles of uncollected garbage littering most estates of the county; and limited sewerage coverage (17%) with more than 80% relying on-site sanitation solutions and a large amount of untreated sewage disposed into the Indian Ocean.

The main forces driving the County's environmental degradation include unplanned and uncontrolled development, poor solid waste and wastewater management and inefficient energy use. Pollution control measures are hampered by inadequate capacity for enforcement of existing public health, environmental and sanitation policies, laws, regulations, guidelines and standards.

2.3 Administrative and political units

The County is divided into six sub-counties namely: **Mvita, Nyali, Changamwe, Jomvu, Kisauni** and **Likoni** and thirty county assembly wards. The national government administrative units within the county include thirty locations and fifty-seven sub-locations as shown in *Table 1* below.

Table 1: Administrative and political Units by Sub-County

Sub-County	Divisions	Wards	Sub-Locations	Villages
Changamwe	1	4	10	58
Jomvu	1	3	7	65
Kisauni	3	6	9	200
Nyali	2	4	8	55
Likoni	2	6	9	145
Mvita	1	7	14	134
Total	**10**	**30**	**57**	**657**

**Source: County Government of Mombasa, the Second CIDP 2018-2022*

2.4 Population and demographic features

According to the 2019 population and housing census, Mombasa County had a population of 1,208,333 persons of which 610,257 and 598,046 were male and female respectively as shown in the *Table 2* below. The population has steadily risen from 341,148 in 1979 to 1,208,333 in 2019.

Table 2: County Distribution of population by sex, households, land area, density and sub-county

Country/County/ Sub-county	Total	Sex		Households			Land area	Density per sq. km.
		Male	Female	Total	Conventional	Quarters		
KENYA	**47,564,296**	**23,548,056**	**24,014,716**	**12,143,913**	**12,043,016**	**100,897**	**580,895**	**82**
MOMBASA	**1,208,333**	**610,257**	**598,046**	**378,422**	**376,295**	**2,127**	**220**	**5,495**
CHANGAMWE	131,882	68,761	63,121	46,614	46,439	175	18	7,457
JOMVU	163,415	83,002	80,410	53,472	53,214	258	37	4,432
KISAUNI	291,930	146,748	145,176	88,202	88,159	43	88	3,328
LIKONI	250,358	126,962	123,392	81,191	80,002	1,189	40	6,187
MVITA	154,171	75,565	78,601	38,995	38,710	285	15	10,543

**Source: KNBS 2019 Kenya Population and Housing Census: Volume II*

The population distribution shows a pyramid that is heavy at the base with majority of the population aged below 30 years. The smallest segment of the population lies on or above eighty years. *Table 3* below shows the age distribution of the population in Mombasa County in 2019.

Table 3: Age distribution

Age Distribution (C 2019)	
0-9 years	277,889
10-19 years	216,157
20-29 years	282,361
30-39 years	211,330
40-49 years	124,085
50-59 years	57,529
60-69 years	26,277
70-79 years	9,440
80+ years	3,209

The population cohorts have been adopted nationally for purposes of estimating requirements for health services delivery in line with the Kenya Essential Package for Health (KEPH). For example, the population under 15 years of age (*children*) constitutes the largest population proportion at 38.5% while pregnant women constitute 3.70% of the population. Each population cohort has its unique health services needs and requirements. *Table 4* shows the Mombasa county population by cohort and key population indicators.

Table 4: Population by Cohorts & Key population indicators

#	Description	Population estimates	Target population			
			2018	2019	2020	2022
1	**Total population**		**1,266,358**	**1,307,942**	**1,347,440**	**1,433,689**
2	Children under 1 year (*12 months*)	3.1%	39,257	40,546	41,771	44,444
3	Children under 5 years (*60 months*)	16.2%	160,481	211,887	171,125	182,079
4	Under 15 years population	38.5%	399,972	503,558	425,791	453,046
5	Women of child bearing age (*15-49 years*)	24.6%	373,548	321,754	397,495	422,938
6	Estimated Number of Pregnant Women	3.7%	46,855	48,394	49,855	53,046
7	Estimated Number of Deliveries	3.7%	46,855	48,394	49,855	53,046
8	Estimated Live Births	3.7%	46,855	43,394	49,855	53,046
9	Total number of Adolescent (*15-24 years*)	24.7%	271,076	323,062	328,775	349,820
10	Adults (*25-59 years*)	32.8%	561,540	429,005	596,916	635,124
11	Elderly (*60+ years*)	4.1%	33,769	53,626	36,381	38,710

Source: DHIS, KNBS

3.1 Introduction

Broadly, despite the largely enabling policy environment and general improvement in the county health profile and indicators over the last decade, Mombasa County still faces several health challenges including high burden of both communicable and non-communicable diseases such as HIV/AIDS, tuberculosis, upper respiratory tract infections, hypertension, diabetes, cancers and malnutrition as well as maternal, newborn and child mortality.

3.2 Disease burden profile

Mombasa County faces several health challenges including high burden of both communicable and non-communicable diseases. The prevalence of the three major communicable diseases in the county stands at 4.1% for HIV/AIDs, 700/100,000 for TB and 8% for malaria. The top five conditions affecting the under five years old in Mombasa include upper and lower respiratory tract infections, diarrhoea, diseases of the skin and confirmed malaria cases. Similarly, the top five conditions affecting the above five years old include upper and lower respiratory tract infections, UTIs, diseases of the skin and diarrhoea. About 80% of all hospital attendance in Mombasa are attributed to preventable diseases and at least 50% of these preventable diseases are linked to poor water, sanitation and hygiene. Poor hygiene, overcrowding, poor waste disposal and environmental pollution have led to increased incidences of diarrheal and respiratory diseases, contributing to the breeding of vectors and infectious micro-organisms. This has, in turn, led to the sporadic outbreak of communicable diseases.

Non-communicable diseases such as hypertension, oncology cases, diabetes, drug and substance abuse are on rise. Although no comprehensive data exists; cancer and cardiovascular diseases are emerging as the leading causes of mortality and morbidity. Sedentary lifestyles of smoking and alcohol consumption influenced mostly by tourism continues to be a major risk factor contributing to the prevalence of these diseases. Drug and substance abuse is high with only three functional drug rehabilitative centres and eight outpatient detoxification centres in the county serving over 600 clients. The burden of violence and injuries is high associated with risky cultural practices and beliefs, road accidents and domestic and gender-based violence. The stigma associated with gender-based violence (GBV) and culture prohibits reporting to relevant authorities for relevant actions to be taken.

3.3 Health sector performance

Over the last five years the sector has achieved considerable outcomes including but not limited to a reduction of Under-Five Mortality (U5MR) from 65 per 1,000 live births in 2013/14 to 33 per 1,000 live births in 2017/18 and Infant Mortality rate from 36 per 1000 live births to 11 per 1000 live births in the same period. The reduction of infant and child mortality rates is attributed to intensified immunization activities including mass campaigns, early detection and case management of Malaria as well as proper use of Long Lasting Insecticidal Mosquito nets to avert malaria incidences. Provision of LLITN's targeting pregnant women increased from 60% to 69%. The increase in health facility deliveries, the proportions of assisted births by skilled health providers during delivery and post-natal care are also cited as factors that lowered both neo-natal and child mortality. However, the proportion of fully immunized children according to DHIS2 data went down from 82% in 2013 to an average of 78% in 2017. This drop was attributed to persistent health workers industrial unrest and a shortage of frontline health workers (HWs).

Maternal mortality reduced from a high of 488/100,000 to 195/100,000. Contraceptive prevalence also increased from 45% to 55% while HIV and AIDS prevalence reduced from a high of 11%, 7.5% to 4.1% in 2018. National Health Insurance Fund Coverage increased from 25% to 31.8%.

Despite notable improvements in key health indicators, there is still inadequate access to quality services due to inadequate health infrastructure and equipment, shortage of qualified and motivated staff, inadequate supply and distribution of health products, quality of health information as well as limited capacity and resources among health workers to handle the county's health system challenges.

3.4 Health Policy and legal context

The national and county policy and legal environment for health has been evolving since the promulgation of the Constitution of Kenya 2010. The Constitution of Kenya requires the government both at the national and county levels to take necessary legislative, policy and other measures, including the setting of standards to ensure universal access to quality healthcare and to fulfil Kenya's international obligations with respect to right to health. At the county level, Article 185(2) of the Constitution vests in the county assemblies the power to make any laws that are necessary for or incidental to, the effective performance of the functions and exercise of the powers of the county government under the Fourth Schedule.

Article 183 (2) of the Constitution provides the county executive committee with the power to prepare proposed legislation for consideration by the county assembly. Among other functions of the county executive committee members include implementation of county legislation, policies and plans as well as national legislation and policies to the extent that the legislation so requires within the county.

3.4.1 National policy and legal framework

The Constitution of Kenya 2010 provides the overarching policy and legal framework for progressive realization of the right to health and health service delivery throughout the Republic. The 4th Schedule to the Constitution distributes health service functions between the national and county governments. At the national level, the key legal instruments include the Health Act No. 21 of 2017, the Public Health Act Cap 242, the Nutritionists and Dieticians Act Cap 253B, HIV and AIDS Prevention and Control Act (2006), the County Government Act, 2012, the Public Finance Management Act, 2012, the Public Finance Management (County Governments) Regulations 2015, the Kenya Medical Supplies Authority Act, 2013, National Health Insurance Act, and the various professional regulation legislation, among others.

The relevant national policy frameworks for health include the Kenya Vision 2030, Kenya Health Policy (2014-2030), the National Reproductive Health Policy (2022), National Adolescent Sexual and Reproductive Health Policy, 2015 (under review), Sessional Paper No. 3 on Population Policy for National Development (2012), the Kenya Community Health Policy 2020-2030,[1] the Menstrual Hygiene Policy (2019 - 2030), the Kenya Environmental Sanitation and Hygiene Policy (KESHP) 2016 – 2030 and the Kenya School Health Policy (2018) and the Kenya Emergency Medical Care Policy of 2021 among others.

[1] *Ministry of Health, Kenya Community Health Policy 2020 - 2030*

3.4.2 The County Policy, legal and Strategic framework

The Mombasa County Integrated Development Plan (CIDP) 2018-2022 is the principal public investment blueprint prepared pursuant to the provisions of Section 126 of the Public Finance Management Act, 2012. The current Mombasa County Integrated Development Plan 2018-2022 re-states the health sector functions for which the Mombasa County Government is responsible as per the Schedule Four of the Constitution of Kenya (2010). The second CIDP 2018-2022 envisions a leading County with a healthy and productive community. The mission of the health sector is to provide the highest attainable standards of quality, responsive and comprehensive health care services to all citizens through innovative, efficient and effective health systems.

The second Mombasa County Health Sector Strategic and Investment Plan (CHSIP II) for 2018-2022 put emphasis on improving the county's response to prevailing disease burden and maintaining a focus on vulnerable populations, and to achieving three key outcomes, namely improved healthy community outcomes; reduced morbidity and mortality; and an informed, supportive and conducive environment for provision of high-quality healthcare services. Specifically, the CHSIP II sought to invest in building the capabilities of its leadership and governance functions, improve health infrastructure, human resources for health, streamline procurement, storage, distribution and rational use of health products and technologies, and domestic resource mobilization and effective use of available financial resources. Other key county policies include the Mombasa County Human Resource for Health Strategic Plan 2015-2018 and Mombasa County Health Quality Management Policy 2022 – 2027 among others.

The key county legislations relevant to healthcare system include:

a. **The Mombasa County Health Act, 2018** provides for the regulation and management of health care services; promoting access to health; establishment of county health system which encompasses public and private institutions and providers of health services in the county and facilitate in a progressive and equitable manner, the highest attainable standard of health services; and the protection, respect, promotion and fulfillment of the right of all persons in the County to the highest attainable care and the right to emergency medical treatment.

b. **The Mombasa County Environmental Health and Sanitation Act, 2017** that provides for the regulatory and enforcement framework for environmental health and sanitation, establishment of environmental health and sanitation standards; and development of sanitation services and investment plans;

c. **The Mombasa County Reproductive Health Care Act, 2017** that provides for the recognition of reproductive rights and setting standards of reproductive health;

d. **The Mombasa County Port Health Act, 2018** that provides for the powers and functions of port health services including to establish, manage, regulate and control port health services; the inspection of vessels to ensure public health standards are met; control of infectious diseases on board incoming vessels by undertaking health checks to vessels; and investigation of reported sickness and deaths on vessels.

e. **The Mombasa County Corporations Act, 2016 No. 8 of 2016** (*Coast General Teaching and Referral Hospital Order, 2019*) and the Executive Order No.1 of 2019 establishing the Coast General Teaching and Referral Hospital CGT&RH as a semi-autonomous county entity in terms of finance, procurement and human resource for effective service delivery.

f. **The Mombasa County Disaster Preparedness and Emergency Management Act, 2017** that provides for the maintenance and operation of an effective system for the anticipation, preparedness for, prevention, coordination, mitigation, management, response to and recovery from emergencies and disasters in Mombasa.

CHAPTER 4: TOR 1: REVIEW OF THE ARCHITECTURE OF HEALTHCARE DELIVERY IN MOMBASA COUNTY

4.1 Mandate of the Task force

The mandate of the Task force was to engage stakeholders including but not limited to the general public, healthcare workers, the National Health Insurance Fund (NHIF) to review the architecture of healthcare delivery including human resources for health and ICT for Health in the County of Mombasa. The overall architecture of health service delivery is embedded in the framework of the devolved health system.

4.2 The Legal Framework

The Constitution of Kenya and the Health Act No. 21 of 2017 defines the architecture of healthcare delivery in Kenya both at the national and county levels. The most significant feature of the Constitution of Kenya 2010 is the introduction of a devolved system of government consisting of the national government and forty-seven county governments. The governments at the national and county levels are "distinct and interdependent," and are expected to undertake their relations through "consultation and cooperation" (Article 6). The distinctiveness of both levels of government are determined by the functions assigned to each level of government under the Fourth Schedule of the Constitution.

Article 186 of the Constitution of Kenya 2010, broadly classifies the health functions between the two levels of government as exclusive, concurrent and residual functions even though to a large extent, the powers and functions relating to health shared between both levels of government. Part 1 of the Fourth Schedule of the Constitution assigns the national government the responsibility for national health policy, national referral health facilities, disaster management, international health, capacity building and technical assistance to the counties, public investment, regulation, quality assurance and standards, and national healthcare agencies, infectious disease control programs, national statistics and data on population, education policy, university and tertiary educational and research institutions among others.

Articles 6 (3) of the Constitution requires national state organs to ensure reasonable access to their services in all parts of the Republic in so far as they are appropriate to do so having regard to the nature of the service. Article 174 (h) of the Constitution provides that one of the object of devolution of government is to facilitate the decentralisation of State organs, their functions and services, from the capital of Kenya.

The Fourth Schedule Part 2, Article 2 vests the county governments with the responsibility for county health services including county health facilities and pharmacies; ambulance services; and promotion of primary health care among others. Regulation and management of human resources for health at both national and county levels is conducted within the norms and standards set by the National government in accordance with the relevant legislation and policies. Article 176(2) of the Constitution requires every county government to decentralise its functions and the provision of its services to the extent that it is efficient and practicable to do so.

Section 48 of the County Government Act, 2012 provides the unit to which the functions and provision of services of each county government are to be decentralized to including — (a) the urban areas and cities within the county established in accordance with the Urban Areas and Cities Act (No. 13 of 2011); (b) the sub-counties equivalent to the constituencies within the county established under Article 89 of the Constitution; (c) the Wards within the county established under Article 89 of the Constitution and section 26; (d) such number of village units in each county as may be determined by the county assembly of the respective county; and (e) such other or further units as a county government may determine.

In exercise of the powers and functions vested in them, the Constitution under Articles 6 and 189 of the Constitution places a duty on the two levels of government to consult and cooperate in order to ensure a harmonious and coordinated delivery of health services in the country. The governments at either level can cooperate by assisting, supporting, consulting and as appropriate implementing the legislation of the other level of government; liaising with government at the other level for the purpose of exchanging information, coordinating policies and administration and enhancing capacity; and co-operating in the performance of functions and exercise of powers and, for that purpose, may set up joint committees and joint authorities; and setting up mechanisms for resolving intergovernmental disputes. The Intergovernmental Relations Act 2012 provides for the establishment of the structures to facilitate the intergovernmental relations. These structures include the Summit, the Council of Governors (COG), the Sectoral intergovernmental forums and the Intergovernmental Technical Committee.

Inter-governmental cooperation for better service delivery in the health sector may take different forms including facilitation of a particular health service to many needy people across all the counties; adjacent counties sharing a facility or facilities or equipment and costs for the benefit of the residents of all the counties; and joint purchase drugs and commodities as a cost-effective measure among others. This however, must be conducted in a manner that respects the functional and institutional integrity of government at the other level, and respect the constitutional status and institutions of government within the county level.

The Health Act No. of 21 of 2017 establishes a devolved health system for the provision of health services at the national and county levels; the co-ordination of the inter-relationship between the national government and county government health systems; and the regulation of health care services, health care service providers and health technologies. Section 3(a) of the Health Act 2017 provides that one of the objects of the Act is to establish a national health system which encompasses public and private institutions and providers of health services at the national and county levels and facilitate in a progressive and equitable manner, the highest attainable standard of health services. Section 23 provides both national and county governments the power to enter into public-private partnerships for the purpose of establishing and deepening health service provision.

Section 25 and the First Schedule to the Health Act, 2017 provides the technical classification of levels of health service delivery including - Level 1: Community Health Services; Level 2: Dispensary/clinic; Level 3: Health Centre; Level 4: Primary Hospital; Level 5: Secondary Hospital; and Level 6: Tertiary Hospital. The county governments are responsible for management of county health facilities and pharmacies (levels 2-5); ambulance services; promotion of primary health care (levels1-3); and public and environmental health related functions including preventive and promotive services, licensing and control of undertakings that sell food to the public, cemeteries, funeral parlours crematoria and refuse removal, refuse dumps and solid waste disposal.

4.3 The county health system and service delivery architecture

4.3.1 Mombasa County health system organizational architecture

The county health system organizational structure is expected to provide a framework for order and coordination of the various health functions and powers of the county government as assigned by the Fourth Schedule of the Constitution. The vision of the Mombasa county health system is ***"a leading County with a healthy and productive community"*** while the county's mission is "to provide the highest attainable standards of quality, responsive and comprehensive healthcare services to all citizens through innovative, efficient and effective health system."

The county department of health (CDOH) is headed by the County Executive Committee Member for health (CEC) and supported by the Chief Officer who is the chief accounting officer of the department. Since 2017, the department has been technically organized into two Medical Services, headed by a Chief Officer, supported by a Director for Medical Services to oversee service delivery at level 4 and 5 health facilities; and Public Health headed by a Chief Officer, supported by Director for Public Health to oversee primary healthcare service delivery at Levels 2 and 3, preventive and promotive (*public and environmental health*) health services and community health services. In addition, there is the support (*cross-cutting*) directorate of administration and human resources management. The County health system is decentralized to the sub-counties, overseen by the Sub-county MoH and Health Management Teams and Facility and to the hospitals, health centres, dispensaries and community health units, overseen respectively, by hospital Boards and medical superintendents, health facility management committees and facility in-charges and community health committees and Community Health assistants.

In 2019, through an Executive Order No.1 of June 2019, H.E. Governor Hassan Ali Joho established the Coast General Teaching and Referral Hospital (CGTRH) as a County Corporation under the CDOH thereby giving the Hospital a semi-autonomous status. The CGTRH is governed by a Board and managed by a Chief Executive Officer with 3 deputies. This semi-autonomous structure was purposefully constructed to give CGTRH independence in managing its Finances, Procurement and Human resource functions; and to carry out additional responsibilities of training and research, to ensure quality and efficiency in health service delivery.

Further, vide the Gazette Supplement No. 12 dated 6th August, 2019, Hospital was assigned five Outreach Centres at level 3B namely; Chaani, Vikwatani, Marimani, Mtongwe, and Shika Adabu to operate based on a hub and spoke model. On the 7th of May 2021, H.E. Governor Ali Hassan Joho through an Executive Order No 1 of 2021 directed that Utange Dispensary be an established outreach Centre of CGTRH and this was gazetted in the Gazette Notice No. 4212. The facility was transformed to a modern 200-bed Utange Field Hospital at level 4 service to handle the Covid-19 crisis and now designated to serve as an Infectious Disease Centre for any future pandemics that may affect Mombasa County.

The new structure elevated the CEO of the CGTRH to the level of a chief officer reporting directly to the CECM for Health. The three units in the Department of Health, namely:- Medical Services, Public Health and CGTRH, interact in several areas i.e. budgeting, Annual Work Plan (AWP), Annual Performance Review (APR), Departmental Human Resource Management Committee (DHRMAC) and Program Based budgeting (PBB).

SUMMARY OF ISSUES AND CHALLENGES

1. **Policy and legal environment**
   a. Inadequate implementation and operationalization of national and county policies and laws;
   b. Little understanding of the existing applicable national and county policies and laws by the departments and other stakeholders.
   c. Inadequate county policy and legislative framework for the full implementation/operationalization of the Right to Health (*Article 43*) and related provisions and the Fourth Schedule
   d. Lack of county exemption and waiver policy and legislation

2. **Organization of the county health sector and governance**
   a. Lack of a multi-sectoral County Health Board for sector-wide oversight and coordination
   b. Unclear interdepartmental communication between the three sub departments
   c. All Level 4 Hospital boards are not constituted
   d. Two versions CDOH Organogram presented to the Task force
   e. Intertwined roles with unclear demarcation of roles, responsibilities/functions
   f. Weak governance and leadership capacity within the various county health system organs and structures

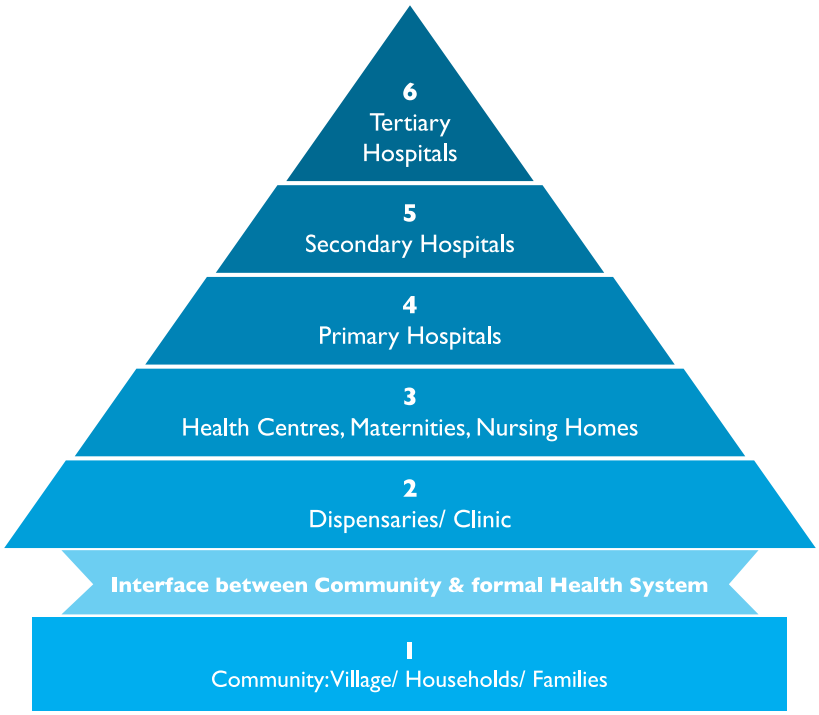
3. **Transition of the CGTRH to semi-autonomous status**
   a. Incomplete transition of the CGTRH to full semi-autonomous status with the Finance Committee not completing its work and submitting its report
   b. Lack of clarity on the relationship between CGTRH as a county corporation under the CDOH and the reporting lines in relation to the CDOH Chief Officer responsible for medical services
   c. Lack of clarity on the administrative responsibility of the Chief Officer responsible for medical services over the CGTRH CEO.
   d. The status of the CGTRH Board - Should it be an Executive Board
   e. The legal character of the CGTRH as a county corporation

4.3.2 Health service delivery architecture

The First Schedule to the Health Act, 2017 provides the technical classification of health facilities at **Level 2: Community health services; Level 2: Dispensary/clinic; Level 3: Health Centre; Level 4: Primary Hospital; Level 5: Secondary Hospital; and Level 6: Tertiary Hospital** as shown in *Figure 1*. The first five levels (*Levels 1-5*) are managed within the county health system while the sixth level is managed by the national government within the national health system. Health services in Mombasa county are provided by public government facilities, faith-based/ NGO health facilities and private health facilities across the six levels of health service delivery system as per the prescribed package of service for each levels.

The relationships between the different levels (*1-6*) works through a referral system which enable clients' health needs to be comprehensively managed using resources beyond those available where they access care by means referral of clients from an initiating facility to a higher level facility that can better provide the level of care needed.

Figure 1: Healthcare Service Delivery structure



Mombasa County has a total of 265 facilities, out of which 46 (17%) are public and 219 (83%) are private as shown in the *Table 5* below.

Table 5: The number of health facilities (Levels 2-5) by ownership in Mombasa

Ownership type	Level 5	Level 4	Level 3/2	TOTAL
Public	1	4	41	46
Private	0	14	194	208
FBO	0	1	8	9
NGO	0	1	1	2
Total	**1**	**20**	**244**	**265**

The Coast General Teaching and Referral Hospital (CGTRH), is the only apex Level 5 county hospital in Mombasa with a 700 bed capacity. The Hospital operates on a hub and spoke model. The CGTRH the Hub serves as the regional referral Centre for the entire coastal region and beyond with a primary catchment population of 1.3 million, and a secondary catchment population of over 3 million. It offers a wide range of routine, specialized and sub-specialized services including both curative and rehabilitative services. The the six CGTRH Outreach Centres, namely ***Chaani, Vikwatani, Marimani, Mtongwe, Shika Adabu*** and ***Utange*** duly gazetted as such (*spokes*) serve as feeder and screening facilities for early detection of communicable and non-communicable conditions which are referred to the main hub for specialized care. The spokes also serve to de-congest CGTRH. These outreaches are each headed by a Medical Superintendent who reports to a Director of quality & Outreaches services at CGTRH.

The Emergency Care Centres in Mombasa County include Coast General Teaching and Referral Hospital, Likoni Sub-County Hospital and Port-Reitz Sub-County Hospital. For emergency health services the County has a total of 11 ambulances and 16 EMTs of whom 12 are from CGTRH and 4 from the sub-county hospitals. Mombasa county has currently 209 community units (CHUs) which cover approximately 79% against a target of 262 which represents 21 % gap in CHUs coverage.

SUMMARY OF ISSUES AND CHALLENGES

1. **Quality health service delivery across the service chain**
   a. All the public health facilities at all levels do not fully conform to the norms and standards
   b. Inadequately resourced health facilities at various levels according to norms and service standards.
   c. Unstructured grievances, complaints redress and feedback mechanisms across all facilities.
   d. Inadequate access to mental health and adolescent and youth friendly reproductive health services
   e. Ill-equipped and grossly under resourced primary healthcare facilities and services (*Levels 2-3*) leading to unnecessary bypass of the primary health facilities to secondary and tertiary facilities.
   f. Sub-optimal functioning of health facilities at all levels (*Levels 2-5*) due to inadequate funding and human resources
   g. Inadequate adherence to and implementation of service charters
   h. Lack of mechanisms to ensure comprehensive service delivery and patient centered care
   i. Lack of clear policy guidelines on provision of health services by the county government to persons in detention e.g. prisoners/remandees and people in special circumstances
   j. Ineffective regulation of public and private health service providers
   k. Poor image and negative attitude towards public health facilities due to poor adherence to medical ethics and code of practice by health professionals

2. **Emergency Health Services**
   a. Lack of transport policy that defines the type and number of ambulance vehicles required for an effective and efficient emergency transport system at the different levels of health service delivery; a maintenance programme; procedures for the safe and economical use of ambulance vehicles and guidelines for vehicle replacement.
   b. All available level 4 facilities do not have a designated accident and emergency department
   c. There is no centralized ambulance dispatch centre
   d. Weak referral and communication system and processes leading to unnecessary referrals being made, expensive referral processes for the poor
   e. Inadequate training on effective emergency healthcare and referrals especially at community and primary healthcare levels.
   f. Lack of mechanisms/ guidelines to facilitate access to emergency medical care in public and private facilities especially for the poor and vulnerable
   g. Inadequate knowledge and skills in recognizing signs and symptoms of complications that require emergency interventions, and thus produce delays in the referral of cases and loss of lives.
   h. High cost of ambulances - patients pay for fuel to access county ambulance services.

3. **Referral system**

   a. Lack of an effective coordination structure for the oversight of the implementation of the referral strategy.

   b. Lack of a referral bypass policy requiring clients to report at levels appropriate for the management of their health needs, which often results in inappropriate self-referral to higher levels of care.

   c. Lack of standard operating procedures (SOPs) and performance monitoring tools for referral services; this in turn affects the auditing of the referral system and development of continuing education for referral service providers.

   d. Insufficient human resources and infrastructure for their service norms and standards, which affects effective and efficient management of referrals.

   e. Inappropriate referrals which include unnecessary referral, poor quality of referral documentation, lack of communication, and improper destination of the referral.

   f. Lack of effective referral monitoring system that promote system appraisal, feedback, and accountability for provider actions.

   g. Inadequate financing in operations and maintenance of referral services which pose a major challenge in ensuring proper functioning of the referral system.

4. **Community Health Services**

   a. Inadequate integration of community health services into the formal county health service system including outreach services

   b. Sub-optimal functionality of community health units and services due lack of capacity to make services more accessible to the people in need at community and household levels

   c. Weak linkages between Level I community health units and the link-health facilities all levels (*Levels 2-5*)

   d. Inadequate use and appreciation of CHVs by health service providers

   e. Stakeholders and partners in community health space working in silos – duplication of efforts and lack of proper coordination

5. **Public and environmental health services**

   a. Inadequate capacity and investment for provision of public and environmental health services including: water quality monitoring, food quality control, waste management, surveillance of premises, communicable diseases control, vermin & vector control, environmental pollution control, disposal of the dead, chemical safety, hazardous substances control, and air quality management among others.

   b. Inadequate access to all the pillars of public and environmental health service including preventive and promotive health services; public health law enforcement and property inspections; and water and food quality monitoring etc.

   c. Inadequate and unreliable supply of clean and safe water and poor sanitation and hygiene condition in most public health facilities

   d. **Drugs and substance abuse:** The burden of drugs and substance abuse has been shown to be increasing substantially in Mombasa County. The County has put in place Methadone Centers to wean off patients which has assisted to some extent. However, the County lacks any effective and substantial Drug and substance abuse Rehabilitation Centers which play a key role in the return of patients to normal life activity

   e. **Inadequate GBV** services across all areas of the County with only one specialized centre at CGTRH which does not operate 24hrs, forcing survivors to travel long distances seeking these crucial services. The number of HRH trained in GBVRC services is also below recommended levels. Currently SGBV is domiciled at the Department of Youth, Culture and Gender.

4.4 Task force Commentary

The Task force recognizes the significant efforts made to re-organize and strengthen the health system, improve the policy and legal environment and to expand the physical access to healthcare services over the past years. Despite these efforts, there are still several challenges ranging from functional overlaps, inadequate implementation and operationalization of policies and laws and largely dysfunctional service delivery at all levels. From the various engagements with stakeholders at different levels, it was evident that there is need for a total re-think of the functional organization of the county health system, the County Health Service Care System and Service Delivery Model if the objectives of universal health coverage are to be achieved.

4.5 Recommendations

1. **Strengthening policy and legal environment for delivery of quality health services**
   a. Comprehensive review of the legal and policy environment inhibiting universal access to quality healthcare and make necessary recommendations for policy and legal reforms
   b. Review the Mombasa County Health Act, 2018 and the Mombasa County Environmental Health and Sanitation Act, 2017 to provide for enabling framework for sustainable health financing and other related matters;
   c. Develop county health sector functional and fiscal decentralization policy in consultation with the County Treasury to enhance operational efficiency and service delivery at various levels of the health system
   d. Develop county exemption and Waiver policy and legislation in regard of medical expenses

2. **Reviewing and strengthening the organizational structure of the county health sector and governance**
   a. Clarify the functional relationship between the three functional units of the CDOH
   b. Review the functional and organization structure (*organogram*) of the CDOH in relation to the overall county health sector
   c. Institute measures to enhance and strengthen harmony, cohesion and communication between the various functional units of the Department
   d. Establish the Mombasa County Health Management Board
   e. Constitute Hospital Boards for all the level 4 facilities
   f. Carry out governance and leadership capacity and training needs assessment
   g. Provide training and capacity building to facility in charges and managers on financial management
   h. Strengthen intergovernmental relationships between CDOH and other coastal counties and MoH and national agencies such as NHIF, KEMSA, Kenya Tissue and Transplant Authority etc.

3. **Managing transition of the CGTRH to semi-autonomous status**
   a. The process towards the semi-autonomy of the Coast General Teaching and Referral Hospital should be completed in accordance with the applicable laws
   b. The CECM(H) in consultation with CECM (F) to carry out a feasibility Study and develop a Business Model for CGTRH in line with the Public Finance Management Act (*county regulations*) 2015 for approval by the County Executive Committee
   c. Review the Executive Order No.1 of June 2019 establishing CGTRH as a county corporation to ensure conformity to the Constitution and the applicable national and county legislation

4. **Ensuring delivery of quality health services at all levels**
    a. Roles and Functions for all health facilities to be clearly spelt out and areas of inter-linkage well defined, to enhance smooth operations and curb unhealthy competition and duplication
    b. Operationalize and optimize all existing facilities to enhance operational efficiency and service delivery at various levels of the health system as per norms and standards.
    c. Standardize service delivery across all similar levels of care and strengthen level 3s and 4s to ensure all facilities and the referral system function optimally as per laid out norms.
    d. Set up an amenity complex within the CGTRH for financial sustainability
    e. Optimize the CGTRH spokes in areas of infrastructure, HR and equipment to allow easy access to specialized consultation and basic specialized surgical procedures.
    f. Fully operationalize the decentralized SGBVR centres and accessible safe homes (Action Aid and NGAAF)
    g. Establish a fully operational referral forensic Lab(s) for SGBVR
    h. Re-purpose Marimani Outreach and Shika Adabu outreach to function as fully equipped modern male and female drug and substance rehabilitation centres in partnership with stakeholders under the PPP model
    i. Strengthen quality management systems and joint Quality Supervisory Team to have regular monitoring and evaluation of all facilities for sustained quality of care.
    j. All level 4 and 5 facilities to work towards enrolling into International Quality Accreditation Programs SAFECARE, JCIA, COHSASA and ISO.
    k. Establish clear grievance and complaints redress mechanisms at county and health facility (all) levels

5. **Strengthening the emergency health services**
    a. Develop County Referral Policy and Standard Operating Procedures (SOPs) to guide referrals and flow of patients
    b. Develop standardized referral tools to communicate referrals and capture referral data (referral forms, referral registers, data collection and update forms, patient tracking forms, feedback forms, and a directory of services)
    c. Establish a well-structured independent emergency response Centre with adequate ambulances, call Centre, GPS tracking and manned by a manager, nurses and EMTs, all appropriately trained in Emergency Medicine. This facility will act as first response to all emergencies within the county.
    d. Establish well equipped accident and emergency medicine department at all the Level 4 and Level 5 facilities with appropriate number of ambulances for referral and cross referral purposes.
    e. Define and refine the county disaster including mass casualty incidences and disease outbreaks response Policy spelling out roles at various levels
    f. Review the functionality of the referral system and explore the use of Hub and Spoke Model
    g. Review, re-organize and upgrade the county, facility and community-based emergency service
    h. Optimize the ambulance service in collaboration/ partnership with private sector e.g. KRC (EPlus) to ensure timely access to emergency services in the communities
    i. Strengthen the emergency and referral system including upgrading of the county and facility ambulance service and ensure timely access to emergency care (*ambulances in the communities*)

6. **Optimizing public and environmental health services**
    a. Review and re-organize the county and city public and environmental health and WASH services including strengthening enforcement capacity in line with the law and best practices
    b. Optimize the delivery of public and environmental health services e.g. inoculation, health certificates, food handling, food quality testing, mortuary and cemetery etc.
    c. Develop business model for public and environmental health services including provision of healthcare waste management service
    d. Establish a county referral food and water safety laboratory
    e. Promote preventive and promotive healthcare
    f. SGBV comprises two components, i.e., preventive and advocacy as well as curative and preventive. The Task forces proposes that -
        i. The Department of Health handles the critical aspects of treatment and support of the legal systems in terms of handling cases and the medical care
        ii. The functions be transferred to the department of Health Services for execution of preventive, advocacy and psychosocial support, curative and supporting of court case.
        iii. Strengthen existing SGBV centres, establish 2 more SGBVRC (24/7 hours) and 2 safe houses within Mombasa County.

7. **Ensuring the full functionality of community health services and units**
    a. Enact Community health services legislation
    b. Regularize the process of recruiting, training, adoption and remuneration of CHVs in line with national guidelines and county legislation.
    c. Fully equip all the existing Level I community health units (209) with essential kits and tools
    d. Ensure full functionality of community health units in line with the Level scope of work and service package
    e. Establish the remaining 21% of CHUs
    f. Employ CHAs to bridge the existing gap in the establishment
    g. Strengthen follow up, feedback and accountability mechanisms, facility-community-family health linkages and outreach services.

CHAPTER 5: TOR 2 & 5: ASSESSMENT OF THE PHYSICAL HEALTHCARE INFRASTRUCTURE IN MOMBASA COUNTY AND RECOMMEND UPGRADING AND SPECIAL PURPOSING OF EXISTING MEDICAL FACILITIES

5.1 Mandate of the Task force

The mandate of the Task force was to engage stakeholders including but not limited to the general public, healthcare workers, the National Health Insurance Fund (NHIF) to assess the state of physical healthcare infrastructure including buildings and heavy and movable equipment in the County of Mombasa and to recommend the upgrading and/or special purposing of existing medical facilities.

Health infrastructure is a key pillar in health service delivery, and is one of the eight policy orientations in the Kenya Health Policy, 2014-2030. The overall goal with regard to health infrastructure is to provide a network of functional, efficient and sustainable health infrastructure for effective healthcare service delivery to all people.

5.2 Legal Framework

The Health Act 2017 provide the primary legal framework for development and management of public health facilities. Section 20 (b) (n) of the Health Act, 2017 vests in the county governments the responsibility for service delivery, including the maintenance, financing and further development of health services and institutions that have been devolved to it; and making known to the public at all times the health facilities through which generalized or specialized services are available to them.

Part III Section 22 on public health facilities requires the county governments to ensure the progressively equitable distribution throughout the county of such publicly owned health institutions, including hospitals, health centres, pharmacies, clinics and laboratories, as are deemed necessary for the promotive, preventive and rehabilitative health services.

Section 23 allows county governments to enter public-private partnerships for the purpose of establishing and deepening health service provision.

5.3 Assessment of the physical healthcare infrastructure

The Task force undertook a comprehensive assess of 37 of the 46 public health facilities in Mombasa County. The assessment covered the different components of infrastructure based on Heath Infrastructure Norms and Standards 2017. These Buildings (*Medical and Non-Medical*), Equipment, ICT and Transport Services of various categories. *Table 6* presents the available infrastructure and equipment in public and private facilities in Mombasa.

Table 6: Available services/ Equipment in public and private facilities in Mombasa

Types of Service /Equipment	Level 5	Level 4	Level 3	Level 2
Health Facilities	1	16	96	134
Total No. of Beds	700	900	124	0
Comprehensive Cancer treatment centres	1	0	0	0
Number of ICU beds	22	36	0	0
Number HDU Beds	28	9	0	0
No. of Renal dialysis Beds	20	29	0	0
No. of operating theatres	5	34	0	0
No of delivery Beds	15	46	27	51
No. of maternity beds	68	102	35	51
Facilities with MRI	1	4	0	0
Facilities with CT Scan	1	5	0	0
Number of facilities providing basic X-Ray services	1	14	0	0
Mental Unit	0	1	0	0

The Task force observed imbalances in facility geographical distribution with 6 Wards without public health facilities, namely Bofu, Kipevu, Port Reitz, Mjambere, Bamburi and Magogoni. Most of the facilities do not meet the required minimum standards for the provision of their level of service.

SUMMARY OF ISSUES AND CHALLENGES

1. **Infrastructure development and facility maintenance**
   a. Incomplete infrastructure projects are e.g. Shika Adabu Hospital, Mvita Health centre Conference room, refurbishment of 3 blocks at Magongo Dispensary, Khaderboy Mat Clinic, Shika Adabu MAT Clinic, Portreitz MAT clinic and resource centre at PHD, Maternal shelter at CGTRH
   b. Inadequate or lack of infrastructure and basic equipment for rehabilitative services including physiotherapy, orthopedic and occupational therapy rooms
   c. Old facilities are dilapidated, poorly maintained, leaky, cracked and structurally unsafe and unsuitable for healthcare settings. Poor maintenance and non-repair of health infrastructure attributed to poor planning, inadequate budget allocation for maintenance and lack of preventive maintenance
   d. A number of health facilities have buildings with asbestos roofing materials (*Port Reitz, Chaani Outreach, Bamburi, CGTRH and Kharderboy*)
   e. A number of equipment's and machines such as X-ray, laundry machines are either broken down or un-serviceable
   f. Obsolete equipment occupying much needed spaces in facilities
   g. A number of facilities lack title deeds and do not have perimeter walls to enhance security, a situation that has encouraged encroachment and /or boundary disputes over facility land
   h. Lack of land for development of new public health facilities
   i. Inadequate financing and budget allocation for health infrastructure development and maintenance
   j. Poor road networks in informal settlements

2. **Functionality of public health facilities in line with norms and standards**
    a. Inadequate number of public health facilities and infrastructure with only 17% (46) facilities under the MCG.
    b. Most of the facilities do not meet the required minimum standards for the provision of quality healthcare at their respective levels of service due to optimally function
    c. A number of Level 3 facilities lack or have inadequate inpatient facilities
    d. Basic radiological and imaging services are generally unavailable
    e. Except for Portreitz Hospital all the other level 4 facilities namely Tudor, Likoni and Mrima maternity have a bed capacity below the minimum requirement (150 beds) e.g. Likoni 24, Tudor 20 and Mrima 50.
    f. Shortage of available space for specialised clinics in most of level 4 facilities hence the clinic days are limited due to unavailability of space (*SOPC, GOPC and MOPC shared in same room*).
    g. Inadequate laboratory spaces (*separate rooms for Microbiology, Biochemistry, Haematology and blood bank*)
    h. All the level 4 hospitals do not have a functional NBU, HDU and dialysis services.
    i. Unavailability of an isolation/infectious disease unit in the entire county.
    j. Unstable and unreliable power supply with many facilities lacking power backup.
    k. Lack of modern and appropriate warehousing and storage infrastructure and facilities.
    l. Many health facilities lack air conditioners
    m. Poor healthcare waste management facilities e.g. lack of environment friendly incinerators
    n. Lack of adequate blood storage and oxygen production facilities
    o. Inadequate provisions of occupational health and safety of healthcare workers
    p. Most health facilities are not PWD friendly
    q. Inadequate or weak communication and security systems and infrastructure
    r. Inadequate disaster and emergency preparedness - some facilities lack firefighting equipment, clearly marked fire exits and SOPs
    s. Most of health facilities lack waste management systems

3. **Special purposing of existing facilities to function as centers of excellence**
    a. Under-utilization of facilities that can be of special purpose and leverage on health tourism opportunities
    b. Insufficient specialised healthcare services

5.4 Task force Commentary

The Task force observed through the facility visits and stakeholder engagements that most of the public health facilities do not meet the required minimum standards for the provision of quality healthcare at the respective levels of service. The existing public health facilities are overstretched while many health facilities are in dilapidated state with poorly maintained infrastructure and equipment. There are also imbalances in geographic distribution of public health facilities with some areas in the county having disproportionately more health facilities than others.

The Task force further observed a number of development projects which are either incomplete or stalled various reasons including pending bills. Most health facilities are grappling with security including security of tenure with majority of the health facilities lacking title deeds and perimeter fences, proper security lighting systems and CCTVs.

Furthermore, most facilities lack proper warehousing/storage infrastructure, adequate and reliable electricity supply, adequate and reliable water supply and sanitation facilities and environmental friendly incinerators and proper fire emergency systems. The need for increased county investment in infrastructure development and facility maintenance and rehabilitation, with priority given to areas with least health facility coverage was pronounced everywhere the Task force visited.

5.5 Recommendations

1. **Infrastructure development and facility maintenance**
   a. Review and clear all pending bills to ensure completion of all ongoing and/or stalled infrastructure development projects
   b. Dispose and replace obsolete equipment in all facilities as per the Public Procurement and Asset Disposal Act
   c. Review/audit the state of all health facility buildings, plant and equipment
   d. Ensure all facilities have in place and implement preventive maintenance/renewal/rehabilitation plans and schedules plans
   e. Prioritize rehabilitation, renovation and maintenance of existing building infrastructure at all levels of care giving priority to the ageing and dilapidated buildings
   f. Conduct an audit of the land tenure (*title deeds*) status of all public health facilities
   g. Develop Mombasa County Health Master Plan and ensure all health facilities have individual master plans that align with the County Health Master Plan
   h. Develop a sustainable financing model for development and maintenance of infrastructure, plant and equipment
   i. Ensure all health facilities install user friendly infrastructure and services e.g. for PWDs, children, adolescents and young people and the elderly

2. **Optimize the functionality of public health facilities in line with norms and standards**
   a. Establish Container clinics in the 6 wards without a public health dispensary to increase coverage and access in especially under-served areas and informal settlements
   b. Increase the bed capacity of Tudor, Likoni and Mrima maternity to attain the minimum requirement for level 4 facilities (150 beds)
   c. Operationalize and optimize all the CGTRH's outreach facilities
   d. Enable level 4 hospitals to have functional NBU, HDU and dialysis services
   e. Explore PPP Models for equipment leasing and routine laboratory examination as a backup and histopathology and sample referral
   f. Develop policy guidelines on donated equipment and machines
   g. Enable facilities to negotiate for a service contract for all the equipment and machines
   h. Procure environmentally friendly incinerators with adequate capacity for all the Level 4 and 5 facilities and crematorium
   i. Ensure availability of liquid Oxygen tanks in all the Level 4 facilities through PPPs.
   j. Install CCTV cameras at all health facilities, giving priority to all levels 4 and 5 facilities in the immediate.

k. Install perimeter walls, and gates in all health facilities

l. Explore alternative energy sources and develop energy diversification plan towards clean and green energy sources such as solar power for all health facilities to reduce dependence on costly national grid

m. Conduct comprehensive disaster and emergency preparedness in all health facilities.

3. **Re-purposing selected health facilities to function as centres of excellence**

a. Prioritise the setting of Speciality Hospitals- Specialist hospitals are widely recognised for their excellence within individual specialties as they perform well and are seen as demonstrating a stronger culture of service innovation. The department should adopt a specialty hospital model which can be implemented in a phased approach. The following health facilities are proposed for upgrading and re-purposing into centres of excellence in provision of specialty health services:

b. Optimize the CGTRH spokes in areas of infrastructure, HR and equipment to allow easy access to specialized consultation and basic specialized surgical procedures

c. Repurpose Tudor Sub County Hospital into a Maternity and Children Centre

d. Repurpose Mvita Sub County Hospital into an EYE, EAR and SKIN Centre

e. Establish a specialized mental health hospital in Port Reitz and transfer the current Port Reitz Hospital mental health unit services to the newly established hospital.

f. Complete and fully equip Utange Field Hospital to function as the County Infectious Disease Hospital and to also serve as the Level 4 Secondary care facility for Kisauni Sub county.

g. Upgrade Mrima hospital to be fully fledged maternity and family health hospital

h. Repurpose Marimani and Shika Adabu Outreach Centres to function as fully equipped modern male and female drug and substance abuse rehabilitation centres.

i. Repurpose and redesign Likoni Sub-County into a Surgical Hospital

j. Upgrade Jomvu Model Health centre to level 4

k. Upgrade Mlaleo Health Centre to level 4

l. Repurpose Mtongwe outreach to operate as a general hospital offering specialized clinic and medical services.

m. Strengthen communication between the CGTRH and other levels of service delivery and coordination with both Public health and Medical services units.

CHAPTER 6: TOR 3: AUDIT THE STATE OF FINANCING FOR HEALTHCARE IN MOMBASA COUNTY

6.1 Mandate of the Task force

The mandate of the Task force was to engage stakeholders including but not limited to the general public, healthcare workers, the National Health Insurance Fund (NHIF) to audit the state of financing for healthcare in the County of Mombasa. Healthcare financing relates to the systems and the process of ensuring adequate financial resources are mobilized, allocated, managed and utilized to provide quality health services and related health programmes. Article 175 (b) of the Constitution of Kenya provides that county governments shall have reliable sources of revenue to enable them to govern and deliver services assigned to the county governments under the Fourth Schedule effectively.

6.2 Legal Framework

The Constitution of Kenya (2010), the County Government Act, 2012, Public Finance Management Act, 2012, the Health Act 2017 and the National Hospital Insurance (Amendment) 2022 provide the basic legal framework for health financing and management at both national and county levels.

The Constitution vests in the State at both national and county government levels, the primary duty of providing the financing required for the provision of healthcare services both as a government function under the Fourth schedule and human right guaranteed under Article 43 of the Constitution. The Constitution under Article 20 (5) requires the State to allocate adequate resources towards the fulfilment of the social and economic rights including the right to the highest attainable standards of health guaranteed under Article 43 of the Constitution. Thus under Article 20 (5), in case the state claims that it does not have the resources to implement e.g. the right to health under Article 43, a court, tribunal or other authority is to be guided by the following principles– (a) it is the responsibility of the State to show that the resources are not available; and (b) in allocating resources, the State shall give priority to ensuring the widest possible enjoyment of the right or fundamental freedom having regard to prevailing circumstances, including the vulnerability of particular groups or individuals.

Alongside the division of functions between the national and county governments under the Fourth Schedule, the Constitution of Kenya 2010 assigns fiscal powers to the two levels of government. Article 187(2)(a) of the Constitution specifically provides that if a function or power is transferred from a government at one level to a government at another level, arrangements shall be put in place to ensure that the resources necessary for the performance of the function or exercise of the power are transferred. This sets out the fiscal principle of devolution that funds must follow and match functions in order to avoid mismatch between functional responsibilities, plans and allocation of available resources at and between national and county governments.

Article 175(b) of the Constitution requires county governments to have reliable sources of revenue to enable them to govern and deliver services assigned to the county governments under the Fourth Schedule effectively. The main sources of county revenues include the equitable share of revenues raised nationally, own tax revenues, service charges, loans, gifts and conditional or unconditional grants among other sources.

Article 202 (1) (2) provides for the equitable sharing of revenues raised nationally among the national and county governments and that county governments may be given additional allocations from the national government's share of the revenue, either conditionally or unconditionally. Article 204(2) (3) provides for the use of the Equalisation Fund to provide basic services including water, roads, health facilities and electricity to marginalised areas either directly, or indirectly through conditional grants to counties in which marginalised communities exist.

Article 209 (1) (3) provides the power to impose tax in both national and county governments. On the one hand, the Constitution vests in the national government the power to impose income tax, value added tax, customs duties and other duties imposed on import and export good and excise tax. On the other hand, the county governments are assigned the power to impose property rates, entertainment taxes and any other tax that the county may be authorized to impose by an Act of Parliament. Article 209 (4) of the Constitution further gives both national and county governments the power to impose charges for services they may provide. Article 212 gives the county governments to borrow only if the national government guarantees the loan; and with the approval of the county government's assembly.

Article 207 (1) of the Constitution establishes Revenue Fund for each county government, into which all money raised or received by or on behalf of the county government are paid, except money reasonably excluded by an Act of Parliament. Article 207 (4) (b) of the Constitution also gives county governments the power to establish other funds and the management of those funds in accordance with a national legislation. Article 176 (2) requires every county government to decentralize its functions and the provision of its services to the extent that it is efficient and practicable to do so. Article 220 of the Constitution lays down the principle of common content for national and county level structure of the budget and development plans.

Article 185 (3) (4) vests in the county assembly, while respecting the principle of the separation of powers, the power to oversight the county executive committee and any other county executive organs and receive and approve plans and policies for the management of the county's resources; and the development and management of its infrastructure and institutions. Article 228 (4) (5) (6) gives the Controller of Budget the power to oversee the implementation of the budgets of the national and county governments; to authorize or not approve any withdrawals from public funds unless satisfied that the withdrawal is authorised by law; and to submit to each House of Parliament a report on the implementation of the budgets of the national and county governments. Article 229 (4) (7) (8) vests in the Auditor-General the power to audit and report on the accounts of the national and county governments and the accounts of all funds and authorities of the national and county governments and to submit audit reports to Parliament or the relevant county assembly. The Parliament or the county assembly is required within three months after receiving an audit report to debate and consider the report and take appropriate action. Under Article 216 (2) one of the principal functions of the Commission on Revenue Allocation is to make recommendations on other matters concerning the financing of, and financial management by, county governments, as required by the Constitution and national legislation.

Public Finance Management Act, 2012 provide for the effective management of public finances by the national and county governments; the oversight responsibility of Parliament and county assemblies; the different responsibilities of government entities and other bodies. Section 104 (1) (b)(d) vests in the County Treasury the responsibility for preparing the annual budget for the county and coordinating the preparation of estimates of revenue and expenditure of the county government and mobilising resources for funding the budgetary requirements of the county government and putting in place mechanisms to raise revenue and resources.

Under section 107 (2) (b) (d) of the PFMA, it is also the responsibility of the County Treasury to enforce fiscal responsibility principles including ensuring that over the medium term, a minimum of thirty percent of the county government's budget shall be allocated to the development expenditure; and that the county government's borrowings shall be used only for the purpose of financing development expenditure and not for recurrent expenditure.

Section 109 of the establishes the County Revenue Fund in accordance with Article 207 of the Constitution into which all money raised or received by or on behalf of the county government is paid except money that is excluded from payment into that Fund because of a provision of this Act or another Act of Parliament, and is payable into another county public fund established for a specific purpose. Section 110 of the Act gives the County Government Executive Committee power to establish county government Emergency Fund to enable payments to be made in respect of an urgent and unforeseen need for expenditure for which there is no specific legislative authority. Section 116 of PFMA also provides that a County Executive Committee member for finance may establish other public funds with the approval of the County Executive Committee and the county assembly.

For every county public fund established, the County Executive Committee member for finance shall designate a person responsible for administering that fund to ensure that the earnings of, or accruals to a county public fund are retained in the fund and that money held in the fund, including any earnings or accruals is spent only for the purposes for which the fund is established. Section 152(1)(a) and 126 of the PFMA read together with Article 220 of the Constitution links the county budgeting with planning and indicates that the first stage of the budget process will be integrated development planning process which shall include both long term and medium-term planning.

Section 104(1) of the County Governments Act (2012) like PFMA section 152 provides that "... no public funds shall be appropriated outside a planning framework developed by the county executive and approved by the county assembly". Section 107(2) of the Act also states that "*the County plans shall be the basis for all budgeting and spending in a county*". Section 108 (4) of the County Government Act No. 17 of 2012 provides a resource mobilization and management framework for county integrated development plan which should at least:-

a. Include the budget projection required under the law governing county government financial management;
b. Indicate the financial resources that are available for capital project developments and operational expenditure; and
c. Include a financial strategy that defines sound financial management and expenditure control: as well as ways and means of increasing revenues and external funding for the county and its development priorities and objectives, which strategy may address the following:-
    i. Revenue raising strategies;
    ii. Asset management strategies;
    iii. Financial management strategies;
    iv. Capital financing strategies;
    v. Operational financing strategies; and
    vi. Strategies that would enhance cost-effectiveness.

Section 5 (3) (4) of the Health Act 2017 provides that the national and county governments shall ensure the provision of free and compulsory (a) vaccination for children under five years of age; and (b) maternity care, and that the national government shall in consultation with the respective county governments provide funds to county governments to ensure that they enjoy their right to the highest attainable standard of health and healthcare services. Section 20(b) (k) (l) (o) of the Health Act 2017 vests in the county government in furtherance of the functions assigned to it under the Fourth Schedule of the Constitution the duty and responsibility for among others.

a. Service delivery, including the maintenance, financing and further development of those health services and institutions that have been devolved to it;
b. Developing supplementary sources of income for the provision of services, in so far as these are compatible with the applicable law;
c. Making due provision and develop criteria to compensate healthcare facilities for debts arising through failure to secure payment for bills for non-payment of treatment of indigent users; and
d. Developing and promoting public participation in the planning and management of local health facilities so as to promote broad ownership;

The National Hospital Insurance Fund (*Amendment*) Act No. 1 of 2022 provides for the establishment of the National Health Insurance Fund; the National Health Insurance Fund Management Board; and mechanisms of contributions to, and the payment of benefits out of the Fund. Section 3 of the Principal Act as amended provides that the Fund consists of such monies as may be appropriated by the National Assembly, for indigent and vulnerable persons. Section 15 (1B) of the principal Act as amended makes the national government liable as a contributor to the Fund on behalf of the indigent and vulnerable persons identified as such by the relevant government body.

6.3 Essential elements and principles of the health financing function

Health financing is one of the key building block of the health system. It is concerned with raising or mobilizing and allocating adequate funds for health to cover the health needs of the population.[2] Health financing provides the required financial resources and economic incentives for the optimal operation of health system and is a key determinant of health system performance in terms of equity and efficiency in service delivery and health outcomes. A good health financing system enables people to access and utilize needed healthcare services and protect them from financial catastrophe or impoverishment associated with having to pay for the services. It also sets the right financial incentives to providers and users to be efficient and ensure that all individuals have access to effective healthcare.[3]

The core health financing functions include raising sufficient and sustainable revenues to provide essential health services and financial protection against catastrophic medical expenditures; managing and applying the revenues equitably and efficiently to deliver services; and ensuring the purchase of health services in an allocatively and technically efficient manner. Health financing is derived from three broad sources, namely public sector (*expenditures financed out of general revenues and social insurance contributions*); private sector (*expenditures financed out of pocket and by private insurance); and external sources (grants or loans from international funding agencies*).

[2] *World Health Organization (WHO). The World health report, 2000. Health systems: improving performance. Geneva: WHO; 2000. Available at* ***http://www.who.int/whr/2000/en/whr00_en.pdf?ua=1***

[3] *World Health Organization (WHO). Everybody's business-strengthening health systems to improve health outcomes: WHO's framework for action. Geneva: WHO; 2007. Available at* ***http://www.who.int/healthsystems/strategy/everybodys_business.pdf***

6.4 Health financing in Mombasa County

Mombasa County health services are financed through funds appropriated by the County Assembly (*county revenue*), Facility Improvement Fund (FIF), the National Health Insurance Fund (NHIF), National Government conditional and unconditional grants such as user fees foregone, DANIDA grants, Level 5 Hospital Grant, Transforming Health Systems for Universal Care (THSUC) and COVID-19 Grant, corporations (*including health and medical insurance*), user fees/households (*individual out of pocket payments*) and transfers from development partner funding (*donors*) off budget and donations/corporate social responsibility. Households are the major financiers of healthcare, contributing more than half of the total health expenditure. There is a general reduction of funds from donors as well as grants from the National Treasury over time.

Hospitals receive capitations, *Linda Mama*, *EduAfya* and cash collections through user fees from patients and clients receiving services in various facilities. The levels 2 and 3 are expected to provide services for free. The Ministry of Health abolished user fee forgone in 2014 in levels three and below except for a minimum registration fees of 10 or 20 Kshs commonly known as 10/20 policy. Instead, the Ministry committed to releasing compensation to these lower facilities for the free services being offered.

These facilities however, face a lot of challenges due to the inconsistent remittance of User fee forgone from the National Government and disbursement from the county treasury forcing a number of the Levels 2 and 3 facilities to illegally charge user fees.

SUMMARY OF ISSUES AND CHALLENGES

1. **Planning, budgeting and health financing**
   a. Lack of meaningful participation in budget processes
   b. Weak linkage between the Health Facility Annual Work-plans, procurement plans and County approved Budgets and disbursement resulting in low or inadequate funds flow to the public health facilities.
   c. Inadequate budgetary allocation for the health sector
   d. Low development expenditures with high recurrent expenditures
   e. Facilities allocations not included in the final approved budgets giving room for un-authorized or un-planned expenditures and hence risk of misappropriations of the little precious funds for healthcare,
   f. Lack of clear criteria for allocation of funds to health facilities in addition to the own source revenues generated.
   g. Over reliance on diminishing donor funding especially for primary health services, preventive and promotive health programs
   h. Mismatch between policies and funding practices on provision of free health care services at Levels 2 and 3 and for children under 5 years leading to inconsistent remittance of user fees forgone from the National Government
   i. Delays or sometimes failure to disburse funds from the County Treasury to the health facilities forcing the Levels 2 and 3 facilities to charge for services in order to survive.

2. **Health Insurance**
   a. Catastrophic financial risks/expenditures faced by majority of the population in accessing quality health care services with about sixty per cent of deaths occurring due to poor quality care, and non-utilization of the available health services
   b. Low registrations for the NHIF scheme clients hence low capitation rates. Poor quality of services attracting less clients from the catchment population served.

c. Low attendance by clients using the NHIF cards at the public facilities with many of the clients opting to choose private health facilities, and hence transferring the revenues that would have been collected

d. Low claiming rates with NHIF for all schemes including SUPA cover, Linda-mama, Edu-Afya, and the civil servants' schemes resulting in revenue losses

e. Administrative in-efficiencies that result in poor claiming culture, claims made but not submitted to the pre-paid schemes, claims submitted but with errors and out of the agreed terms and conditions resulting in rejections and hence revenue losses

f. Delayed remittance of statutory deductions including NHIF

g. Delayed reimbursement for services rendered such as Linda mama funds puts a strain in continuity of services. delays in getting pre-authorization for particular services under NHIF.

3. **Revenue collection**

a. Lack of standardized tariff policy applied across the county facilities

b. Sub-Optimal revenue collection practices with no targets set for revenue collection by facilities leading to less revenue collected

c. Lack of enabling legal framework to enable health facilities to collect and spend revenues at point of service

d. Regular stock out on Essential Medicines and Medical Supplies (EMMS) and Laboratory reagents and radiology commodities, which create opportunities for revenue leakages,

e. Lack of waiver and exemption policy making administration of waivers open to abuse and political interference leading to loss of revenue

f. Lack of streamlined departmental revenue collection processes and manual collection of cash for services is prone to misuse.

4. **Administrative Support**

a. Inadequate financial management capacity and administrative support for health facilities in charges

b. Delays in appointing the Health Facility Management Committees and Boards. Mostly those appointed are not adequately skilled or their skills do not match that of management of health system

c. Cumbersome path to obtaining authority to incur expenditure (AIE) or even obtain funds from the county Treasury

d. Lack of fiscal autonomy for health facilities

e. Failure to deliberately pay and clear bills thereby putting strain on continuous supply of health products consumables and services.

f. Weak accountability systems/capacity.

6.5 Task force commentary

The Task force noted that the key fiscal challenge for the Mombasa County remains how to effectively mobilize adequate and sustainable resources to finance expenditures for health services and programs without over reliance on development partners and the catastrophic out of pocket expenditure by households. The county does not have a health financing policy. Delays in or inconsistent disbursement of funds including user fees forgone and reimbursements from the national government and NHIF remain a major hindrance. The centralized on-budgeting system from the county exchequer is bureaucratic to access and fraught with delayed budget releases to finance sector activities leading to delays in payment of creditors and chronic stock out of health products and technologies.

As result, the CDOH majorly depends on off-budget financing for program financing which is unpredictable and not sustainable. Revenue collection is not optimized due to challenges in logistics such as lack of computerization of services and incentives to collect the monies.

The County requires innovative health financing models based on a clear classification of the county health system and financing functions that will be able to optimize both public and private sources. It is also imperative that the County Government improves the efficiency and accountability in the utilization of the available budgetary resources through decentralization of fiscal powers and increasing capacity among health system and facility managers in financial management and procurement processes in addition to strengthening of the process requirements.

6.6 Recommendations

1. Increasing budget allocation and crafting innovative health financing model

a. Develop county business and financing model for county health service

b. Increase county budget allocation for health and consider per capita allocations to help better target the marginalized, vulnerable and poor populations and areas

c. Review expenditure structure to repurpose expenditure in areas with highest impact in terms of service delivery

d. Establish a database for all donors (*off and on budget funding*) including corporate social responsibility (CSR)

e. Develop innovative health financing model including leveraging on philanthropic sources and linking business licensing with active enrolment in NHIF

f. Establish County Health Services Fund to ring fence funds appropriated for health services and grants and ensure sustainable financing of health functions assigned under the Fourth schedule and the Bill of Rights including community health services

g. Review and establish a compliance monitoring system for conditional grants e.g., conditions given under Kenya Devolution Support Program (KDSP), national government conditional and unconditional grants

h. Develop health sector public-private partnership framework to leverage on private sector investment and opportunities for optimizing available private sector healthcare services and facilities in the County

i. Training and build capacity of county, health facility and community health teams, boards and committees in county planning, budgeting and public finance management

2. Optimizing health insurance

a. Develop and implement County NHIF revenue collection model to optimize revenues from the NHIF schemes (*supa-cover, Linda-mama, EduAfya and the civil ser vants' schemes*)

b. Reduce incidences of stock outs in the pharmacy and lab departments at the public health facilities

c. Facilitate indigents and small and micro businesses/informal sector enrolment in NHIF

d. Aggressive awareness creation and households' registrations to NHIF scheme be maximized through community health units and county administration structure. Expanded NHIF enrolment and penetration in most of the facilities will automatically influence service with eventual effect on cost for service in the sector

e. NHIF should review and upgrade the facilities levels and reimburse them at the correct levels

f. Ensure all county hospitals are NHIF and other health/medical insurance compliant to be empanelled to receive claims through Linda Mama, capitations etc.

   i. Install NHIF compliant ICT equipment in all health facilities

   b. Establish NHIF desks with personnel in all the health facilities

   c. Train health workers on NHIF component and enforce use of NHIF cards by all eligible clients/ patients including *Educare* (*Secondary Students*)

   d. Establish effective monitoring and evaluation systems to ensure sustainability.

3. Optimizing own source revenues and revenue collection

a. In the immediate, an executive order on facility retention of revenues collected in the facility bank accounts and acknowledged as appropriation in aid (AiA) be issued

b. Fast track enactment of the Facility Improvement Fund (FIF) Bill to enable health facilities raise, retain and use revenues received and to ensure that complementary funding for health facilities is based on performance criteria to discourage dependency, weak revenue collections.

c. Develop county waiver and exemption policy and guidelines to guide sustainable application and administration waivers and exemptions by health facilities/service providers

d. Develop and regularly review county health tariff policy and guidelines for various health services

e. Map revenue sources with an aim at progressively growing the own source revenue (OSR) and allocation to the health sector to ensure that we have adequate financial resources to the health sector,

f. Conduct a baseline on the status of revenue collection against the potential to ensure that revenue is optimized and strengthen revenue collection at all the public health facilities

g. Set targets for revenue collection based on facility workload history and potential workload

h. Carry out regular Performance reviews (Revenues and Service delivery) to ensure that revenue targets are met, expenditure is being directed to prudent use and that complementary funding is helping to meet the budget

i. Reduce operational leakages in revenue management by ensuring that payments for public health services are made at all relevant service station.

j. Fully automate revenue collection and eliminate cash handling at all the revenue collection points by optimizing the use of affordable mobile money transfer, banking and other appropriate digital payment modalities to improve efficiency and accountability

k. Encourage health facilities to establish complementary social support mechanisms e.g. facility social support funds to receive and manage social corporate responsibility funds and donations, grants etc. to support those unable to pay for services and may need waiver or exemption from paying e.g. under 5 years

4. **Enhancing efficiency and administrative support**
    a. To ensure service continuity at health facilities, the County Treasury to ensure that all funds appropriated and earmarked to the health facilities are transferred directly to the facility bank accounts to ensure service continuity. This includes the Level 5 conditional grants and grants for primary healthcare e.g. DANIDA and User fees foregone.
    b. Build the capacity of the public health facilities to optimize both cash and pre-paid scheme revenues and efficiently utilize raised revenue
    c. Review/audit the health sector funds flow framework to ensure that approved budget and appropriated funds for health are not only actually disbursed and but are also fully transferred to the units including health facilities accounts without undue delay.
    d. Remove unnecessary bureaucracy in the payment processing in the supply chain to restore confidence.

CHAPTER 7: TOR 4: EVALUATION OF THE STATE OF SUPPLY CHAINS FOR HEALTHCARE IN MOMBASA COUNTY

7.1 Mandate of the Task force

The mandate of the Task force was to engage stakeholders including but not limited to the general public, healthcare workers, the National Health Insurance Fund (NHIF) to evaluate the state of supply chains for healthcare in the county of Mombasa.

The World Health Organization (WHO) recognizes health products and technologies as one of the key building blocks of a health system. Access to essential health products and technologies entails continuous availability within the context of functioning health systems at all times with assured quality, and at a price that individuals and the community can afford.[4,5]

7.2 Legal Framework

The Constitution of Kenya (2010) provides the overarching framework for the HPTs management under the Fourth Schedule Part 2 (2) (a) (b) (c) on County health services including health facilities and pharmacies. Article 46 (1) provides for the rights of consumers to goods and services of reasonable quality; to the information necessary to gain full benefit from goods and services; to the protection of their health, safety and economic interest; and to compensation for loss or injury arising from defects in goods or services.

The Health Act, 2017 establishes the framework for the regulation of healthcare services, healthcare service providers and health products and technologies. Section 20 (g) of the Health Act, 2017specifically vests in the county governments the responsibility for procuring and managing health supplies. Sections 62 and 63 of the Health Act 2017 establish the framework for the regulation of health products and health technologies including the licensing, manufacturing, laboratory testing and inspection, storage and distribution facilities, clinical trials, advertising and promotion, and post marketing surveillance for quality safety and disposal of health products and technologies.

The Health Act expands the classes of health products to include therapeutic feeds and nutritional formulations. Section 67 (3) on procurement of health products and technologies provides that the Kenya Medical Supplies Authority (KEMSA) may be the point of first call for procurement of health products at the county referral level. Nationally, the Public Procurement and Asset Disposal (PPADA) Act No. 33 of 2015 guides procurement of HPTs.

The KEMSA Act provides guidance for procurement, warehousing, and distribution of essential medicines and medical supplies for the public sector both at the National and county levels. Other legislation applied in management of HPT supply chain include the Public Financial Management Act, 2012, the County Government Act, 2012 and the State Corporations Act, Cap 446.

[4] *WHO (2010), Monitoring the Building Blocks of Health Systems: A Handbook of Indicators and their Measurement Strategies, World Health Organization 2010, Geneva.*

[5] *WHO (2005), Essential medicines [online]. Geneva, World Health Organization, 2005*

7.3 Principles of effective and reliable HPTs supply chain management system

The HPT pillar of the health system lays out broad aspirations for developing effective and reliable procurement and supply systems to improve access to, and quality of HPT. Access to essential health products and technologies entails continuous availability within the context of functioning health systems at all times with assured quality, and at a price that individuals and the community can afford.[6,7] Access to quality and affordable essential health products and technologies (HPT) is not only pivotal to successful delivery of health services and improving health outcomes but also economic development.

The increased demand arising from the affordable Universal Health Coverage (UHC) initiative, changing epidemiological patterns and improved health education for Kenyans creates an even more compelling need for a well-functioning and responsive HPT supply chain. Functionally, HPTs are closely intertwined with the other health system building blocks, namely health service delivery, health financing, HMIS, infrastructure, human resources and leadership and governance.

A well-functioning health system therefore a prerequisite to ensuring equitable access to essential health products and technologies of assured quality, safety, efficacy and cost-effectiveness.

7.4 The state of supply chains for healthcare in the county of Mombasa

The current practices of acquiring health products, technologies and services involves centralized tendering systems. The overall picture that emerged is that the current supply chain management system for healthcare in Mombasa County is weak and characterized by many deficiencies regarding the transparency of the procurement processes, delays in payment of suppliers, high pending bills, chronic stock outs and lack of HPTs for prolonged periods of time.

The overall consequence of the deficiencies is a higher scale of HPT insecurity with far reaching impact on the competitiveness of the public health service providers and limited access to quality and affordable healthcare services by Mombasa residents.

Addressing the many deficiencies and challenges will require fundamental change in the manner the county manages and governs HPT supply chain to ensure among other things, timely, transparent and accountable procurement and distribution of HPTs in accordance with good distribution practice (GDP).

SUMMARY OF ISSUES AND CHALLENGES

1. **HPT Governance**
   a. Despite being a critical health system pillar HPT is not reflected in the current organizational structure of the health department. The HPT functions are exercised under the directorate of curative and rehabilitation services
   b. Weak regulations, laws and poor enforcement of the same.
   c. Lack of up-to-date pre-qualified and approved list of suppliers.
   d. Common perception among the parties of political interference and conflicts of interest in the supply chain processes including awarding of tenders.
   e. Centralized procurement system with lack of clear roles and responsibilities including clarity who is a procurement entity.

[6] *WHO (2010), Monitoring the Building Blocks of Health Systems: A Handbook of Indicators and their Measurement Strategies, World Health Organization 2010, Geneva.*
[7] *WHO (2005), Essential medicines [online]. Geneva, World Health Organization, 2005*

2. **Health products and technologies supply chain**
   a. Some essential drugs and non-pharmaceuticals are not available from the principal supplier KEMSA. The prices of some KEMSA products are rather high compared to other sources in the market
   b. Lack of adequate HPTs in all health facilities
   c. Chronic stock-outs of HPTs for prolonged periods of time at different levels of the current pull system (KEMSA, facilities), high turnover periods and low order fill rates resulting in disruption of services.
   d. Inadequate automated system for HPT logistics management (*reporting and procurement*)
   e. Lack of end-to-end visibility of HPT consumption and patient care data
   f. Inadequate stores, warehouses and dedicated vehicles and loaders
   g. Dilapidated and run-down HPT stores with poor air conditioning facilities
   h. Lack of appropriate facilities and processes for safe and environmentally friendly disposal of HPT waste
   i. Lack of standardized electronic management system for commodities and partial automation of HPT logistics management mainly attributed to program commodities.

3. **Human Resource for HPT**
   j. Shortage of qualified pharmaceutical staff especially at the primary healthcare facilities (*Levels 2 and 3*)
   k. Inadequate support supervision leading to inefficiencies and poor accountability for HPT at various service levels.

4. **HPT financing**
   l. High Pending bill with budget allocations not matching the existing pending bills (*KEMSA and other outstanding debts)*
   m. Although HPT financing is among the largest consumer of the health budget, the HPT financing remains highly inadequate.
   n. Budgetary allocation is not informed by quantification of HPT needs
   o. Fiscal indiscipline where allocated funds for HPT are re-directed to other activities, requisitions not honoured and suppliers not promptly paid.

7.5 Task force commentary

The Task force notes that despite the measures for strengthening availability and affordability of HPT in Mombasa County, HPT supply chain management remains weak characterized by many deficiencies including inadequate regulation and weak supply chain management and governance, financing, and access to quality and affordable essential HPTs due to chronic stock-outs for prolonged periods.

Addressing the many deficiencies and challenges will require fundamental change in the manner the county manages and governs HPT supply chain. This will require enabling county policies, standards, guidelines and regulations and capacity to effectively support transparent and accountable procurement, supply and distribution systems and rational and responsible use of medicines, commodities and equipment.

7.6 Recommendations

1. **Strengthening county HPT governance and management**
   a. Strengthen governance structures for HPT at the County Department of Health (CDOH) for effective leadership and stewardship of the HPT pillar of the county health system
   b. Ensure representation of HPT at the county supply chain management department.
   c. The Chief Officers and CEC should have HPT KPIs in their performance contracts.
   d. Strengthen the Stakeholder partnerships and coordination for HPTs.
   e. Develop and implement capacity building program on HPT supply chain management and governance
   f. Decentralize HPT procurement to facility levels to enable facility in charges and medical superintendents to conduct procurement of vital health commodities and products to reduce bureaucracies
   g. Establish a central procurement support facility for Levels 1-3 facilities and units to oversight, support and guide the procurement that is done at source.

2. **Improving health products and technologies supply chain management**
   a. Enhance the role of HPT unit in HPTs procurement process in accordance with WHO guidelines.
   b. Review procurement system and commission relevant officers to enhance efficient supply chain management and procurement of HPT commodities and assets with proper documentation of guarantees, warranties, after sales service and disposal after its use-able life cycle is over
   c. Establish common HPT purchasing and warehousing system within Mombasa County
   d. Align county HPT supply chain component with the Public Procurement and Disposal Act (PPDA) to ensure uninterrupted supply and resupply of HPTs.
   e. Regularize the process of pre-qualification and update the list of pre-qualified Suppliers.
   f. Establish guidelines for HPT procurement from other entities in addition to KEMSA e.g. MEDS and private supplies through framework agreements.
   g. Enhance commodity security systems to reduce and control pilferage and wastage.
   h. Conduct regular price surveys and standardize the pricing of HPTs for all health facilities
   i. Explore the optimization of the use of PPP framework agreements for HPTs
   j. Digitize HPT systems to ensure end-to-end visibility and accountability
   k. Review the model of ordering/reordering HPTs and harmonize quarterly ordering system for all HPTs initiated from HPT unit/division.
   l. Establish appropriate facilities for safe and environmentally friendly disposal of HPT waste
   m. Review and audit the existing HPT infrastructure and facilities
   n. Establish sub-county HPT stores for bulk medical and public health products and technologies
   o. Strengthen HPT Quality Assurance capacity
   p. Develop Key Performance Indicators (KPIs) for tracking quality of services delivered.

3. **Strengthening Human Resource capacity for HPT management**
    a. Progressively increase HPT workforce especially pharmaceutical staff to align with the norms and standards and to fill the gaps which are currently occupied by non-pharmaceutical staff forced to do task shifting
    b. Conduct a comprehensive capacity and training needs assessment of the HPT workforce
    c. Train and build capacity of staff in commodity management and data visualization/analysis.
    d. Strengthen the support supervision and mentorship system

4. **Increasing budget allocation and investment in HPT**
    a. Clear Pending Bills to ensure timely access to HPTs
    b. Develop county HPT investment plan and innovative financing model to ensure and sustain the uninterrupted resupply of HPT
    c. Allocate and ring fence a proportion of the health facility NHIF funds and capitation for HPT to ensure there are no essential medicines and commodities stock outs and that essential lifesaving medicines are available at all times.
    d. Update IFMIS system with the HPTs in the KEML, Kenya Diagnostic lists and KEMSA LMIS.

CHAPTER 8: TOR 6: AUDIT OF THE PUBLIC HEALTHCARE RELATED HUMAN RESOURCE

8.1 Mandate of the Task force

The mandate of the Task force was to engage stakeholders including but not limited to the general public, healthcare workers, the National Health Insurance Fund (NHIF) to audit public healthcare related human resource currently employed by the County Government and make recommendations on addressing the skills gap. Human Resource for health is one of the core building blocks of the health system. Practically, health systems can only function with health workers and the enjoyment of the right to the highest attainable standard of health is dependent on the availability, accessibility, acceptability and quality of the health workforce.[8] The mere availability of health workforce is however not sufficient to deliver quality healthcare and realize the desired health outcomes.

The health workforce should be equitably distributed and accessible by the population; should possess the required skills and competencies; should motivated and empowered to deliver quality care; and should be adequately supported by the health system.

8.2 Legal framework

The Constitution of Kenya (2010), the County Government Act, 2012 and the Health Act 2017 provide the basic legal framework for the human resources management in the public sphere. Articles 10 and 232 of the Constitution provide the guiding values and principles of governance and public service which apply at both levels of government.

Article 235 of the Constitution provides the framework for the staffing of county government within the norms and standards set by the National government. This includes the power to establish and abolish offices in the county public service; appoint persons to hold or act in county public offices; and power exercise disciplinary control over and removal of persons holding or acting in county public offices.

Article 230 (4) (b) (5) gives the Salaries and Remuneration Commission the powers and functions to advise the both national and county governments on the remuneration and benefits of all state officers and all other public servants and in so doing to take the following principles into account:-

a. The need to ensure that the total public compensation bill is fiscally sustainable;
b. The need to ensure that the public services are able to attract and retain the skills required to execute their functions;
c. The need to recognise productivity and performance; and
d. Transparency and fairness.

The County Government Act No. 17 of 2012 provides for the objectives of the county public service and functions and powers of the County Public Service Board and County Executive Committee in designing and implementing a performance management plan.

[8] *Global Health Workforce Alliance (2014). A universal truth: no health without a workforce. Report of Third Global Forum on Human Resources for Health, Recife, Brazil. Geneva: World Health Organization; 2014 (**http://www.who.int/workforcealliance/knowledge/resources/hrhreport2013/en/.**)*

Section 55 of the County Government Act No. 17 of 2012 sets out the objectives of the county public service which include to provide for - the organization, staffing and functioning of the county public service in ways that ensure efficient, quality and productive services for the people of the county; the institutions, systems and mechanisms for human resource utilization and development in a manner that best enhances service delivery by county public service institutions; the promotion of the values and principles set out in Articles 10 and 232 of the Constitution in the county public service; human resource management and career development practices; addressing staff shortages and barriers to staff mobility between counties; and the standards to promote ethical conduct and professionalism in county public service.

Section 59 of the County Government Act further outlines the functions and powers of the County Public Service Board, which include among other things:-

a. Facilitating the development of coherent, integrated human resource planning and budgeting for personnel emoluments in counties;

b. Advising the county government on human resource management and development and implementation and monitoring of the national performance management system in counties; and

c. Making recommendations to the salaries and remuneration commission, on behalf of the county government, on the remuneration, pensions and gratuities for county public service employees.

The county executive committee under Section 47 of the County Government Act is required to design a performance management plan to evaluate performance of the county public service and the implementation of county policies. The performance management plan should provide for among others objective, measurable and time bound performance indicators, annual performance reports and citizen participation in the evaluation of the performance of county government.

The Health Act, 2017 establishes the framework for HRH management and intergovernmental coordination. Section 20 (f) (i) of the Health Act, 2017 vests in the county government in furtherance of the functions assigned to it under the Fourth Schedule of the Constitution the duty and responsibility for developing and implementing, in consultation with the Salaries and Remuneration Commission, such policies as may be necessary to guarantee the staffing of the public health service in marginal areas including taking into account the use of equalization fund; and providing access and practical support for monitoring standards compliance undertaken within the county by the national government department responsible for health, the Authority and professional regulatory bodies established under any written law. Section 12 of the Health Act outlines the rights and duties of healthcare providers which includes the right to a safe working environment that minimizes the risk of disease transmission and injury or damage to the healthcare personnel or to their clients, families or property.

Sections 30 and 31 of the Health Act, 2017 establishes the Kenya Health Human Resource Advisory Council to review policy and establish uniform norms and standards for, among other things — posting of interns to National Government and County Government facilities; inter county transfer of healthcare professionals; transfer of healthcare professionals from one level of Government to another; the welfare and the scheme of service for health professionals; management and rotation of specialists; and the maintenance of a master register for all health practitioners in the counties. Section 107 (3) considers all specialists be a national asset to sustain internship training and specialist services to ensure standards and equity.

Sections 45 and 48 of the Health Act establishes the Kenya Health Professions Oversight Authority to among others– maintain a duplicate register of all health professionals working within the national and county health system; receive and facilitate the resolution of complaints from patients, aggrieved parties and regulatory bodies; and ensure the necessary standards for health professionals are not compromised by the regulatory bodies. Section 106 and 108 of the Health Act, 2017 provides a framework for inter-governmental collaborations, consultations, cooperation and entering into agreements in various fields such as health workers' welfare.

To ensure effective regulation of the health workforce, there are acts of Parliament that provide for the establishment of various regulatory boards and councils to regulate the training and practice of health professionals, maintain and update registers of active health professionals and ensure continuous quality control in service delivery. Currently there are eight regulatory agencies established through various Acts of Parliament to represent individual professions. These include: the Nursing Council of Kenya (Nurses Act Cap 257), Medical Practitioners and Dentist Board (Medical Practitioners and Dentists Act Cap 253), Clinical Officers Council (Clinical Officers Act Cap 260), Kenya Medical Laboratory Technicians and Technologists Board (Kenya Medical Laboratory Technicians and Technologists Board Act Cap 253A), Pharmacy and Poisons Board (Pharmacy and Poisons Act, Cap 244), Public Health Officers and Technicians Council (Public Health Officers (*Training, Registration and Licensing*) Act No.12 of 2013), Radiation Protection Board (Radiation Protection Act, Cap 243) and Kenya Nutritionists and Dieticians Institute (*Nutritionists & Dieticians Act No. 18 of 2007*).

8.3 Essential elements and principles of effective and productive health workforce

Health Workforce refers to the human resources required for the provision of quality healthcare services. For practical purposes, health systems can only function effectively and efficiently with adequate health workers. The enjoyment of the right to the highest attainable standard of health is also dependent to a large extent on the availability, accessibility, acceptability and quality of the health workforce.[9] Thus for the health system to deliver quality healthcare and to realize the desired health outcomes, the health workforce should not only be available but should also possess the required skills, competencies and attitudes; be equitably distributed and accessible by the population; be motivated and empowered to deliver quality care; and be adequately supported by the health system.[10] The 2013 WHO Report entitled No Health Without a Workforce, offers a useful framework for examining the health workforce,[11] based on the human rights based availability, accessibility, acceptability and quality (3AQ) criterion briefly described below:

a. **Availability:** an adequate number of competent health professionals, distributed according to the needs of the population;
b. **Accessibility:** equitable distribution of health professionals and facilities in terms of travel time, hours of operation, direct and indirect costs of services, and disability friendly infrastructure;
c. **Acceptability:** a professional workforce that is respectful, flexible, and trustworthy; and
d. **Quality:** a workforce that is adequately trained, has provisions for continuous training, and is perceived as competent by the population it serves.

[9] *Global Health Workforce Alliance (2014), A universal truth: no health without a workforce. Report of Third Global Forum on Human Resources for Health, Recife, Brazil. Geneva: World Health Organization; 2014 (**http://www.who.int/workforcealliance/knowledge/resources/hrhreport2013/en/.**)*

[10] *World Health Organization (2016), Global strategy on human resources for health: workforce 2030, World Health Organization 2016, Geneva*

[11] *WHO (2013), No Health Without a Workforce. World Health Organization, 2013*

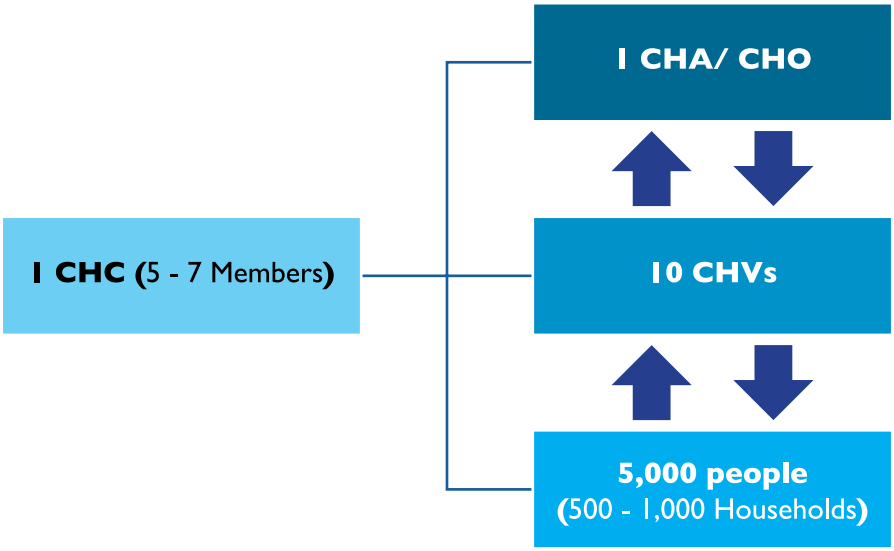
8.4 The human resources for health situation in Mombasa County

The HRH staff has grown over the years since devolution from 1701 in 2014 to the current staffing of 2,382 Health workers. Of this, the CGTRH has 992 (42%) health workers and all the levels 4 facilities have 541 (23%) number of healthcare workers of total health worker force. The level 3 and 2 facilities have 543 (23%) number of healthcare workers. The staff deployed at the management levels at the county and sub county represent 8% (201) of the total health workforce. The number of medical specialists including pharmacists and dental specialists has also increased from 49 in 2014 to 97 in 2022. The total number of specialists is 210 including Clinical and Nurse Specialists. A significant 526 number of the health workforce are casuals employed in various health facilities. Available data indicates that there are 67 skilled casuals, 151 semi casuals and 308 unskilled casuals. Majority of the casuals are in the level 5 and level 4 health facilities. The development partners including Stawisha Pwani, AHF, Global Fund, UHC, NASCOP, Walter Reed and ADS Coast have also employed a total number 211 staffs on contract in various service delivery points.

The current health workforce establishment is highly inadequate and does not conform to the national HRH norms and standards. Of the required staff as per the norms and standards for various levels of care, only 24.87% (2262) are in post, compared to the required staff establishment of 9093. This leaves a gap of 75% (6831) with the most affected levels of care being levels 2-4. Currently, Mombasa County has 92 healthcare workers who are on training undertaking studies in various areas of specialisations of which 65 are doctors.

The Level 1 Community Health Unit forms the first health service delivery structure and covers a population of approximately 5,000-10,000 people (500-1,000 households). Each unit is assigned a workforce of one Community Health Assistant/Officer and 10 community health volunteers. The Community Health Volunteers (CHVs) are members of the community who are selected to serve in a community health unit after undergoing basic and technical training modules to acquire knowledge and skills to enable him or her offer services at level one/community level. Community Health Assistants/Officers (CHAs/CHOs) are formal employees of the County Government forming the link between the community and the local health facility.

Figure 2: Community Health Unit Structure



The current community health workforce consists of 2322 CHVs and 262 Community Health Assistants serving in the 209 community health units.The current community health workforce is under established as per the norms and standards with additional 530 CHVs and 184 CHAs required in post as shown in the *Table 7* below.

Table 7: Mombasa County Community Health Services HRH projection

Mombasa County Community Health Services HRH in position & projection								
S/No	**Sub County**	**CHUs Link Facilities**	**No. of CHUs**	**CHAs in post**	**No of CHVs**	**Target for CHUs**	**GAP for CHUs**	**CHAs Gap per existing CHUs**
1	Changamwe Sub-County	Magongo MCM	10	1	100			9
		Bokole CDF Health Centre	6	1	64			5
		Chaani CGTRH	8	1	86			7
		Port Reitz Sub County	8	1	86			7
		TOTAL	**32**	**4**	**336**	**35**	**3**	**28**
2	Jomvu Sub-County	Jomvu Dispensary	7	1	70			6
		Jomvu model	5	0	50			5
		Mikindani MCM	10	1	100			9
		Miritini CDF	8	1	80			7
		Miritini MCM	2	0	20			2
		TOTAL	**32**	**3**	**320**	**36**	**4**	**29**
3	Likoni Sub-County	Mbuta Model H/C	2	1	40			3
		Mtongwe Dispensary	3	0	30			3
		NYS Dispensary	4	1	40			3
		Kidunguni Dispensary	4	0	40			4
		Shika Adabu Dispensary	9	1	90			8
		Likoni S County Hospital	15	1	150			14
		Mrima Health Centre	18	0	180			18
		TOTAL	**55**	**4**	**570**	**59**	**4**	**51**
4	Nyali Sub-County	Bamburi dispensary	6	1	110			5
		Kisauni dispensary	5	1	100			4
		Ziwa la ng'ombe H/C	6	1	60			5
		Maweni dispensary	5	1	50			4
		Kongowea Health Centre	5	1	60			4
		TOTAL	**27**	**5**	**380**	**40**	**13**	**22**
5	Mvita Sub-County	Railway Dispensary	3	1	40			2
		Ganjoni clinic	2	0	17			2
		Mvita clinic	1	1	22			0
		Majengo Dispensary	2	0	15			2
		Mwembe Tayari clinic	2	0	13			2

S/No	Sub County	CHUs Link Facilities	NO. of CHUs	CHAs in post	No of CHVs	Target for CHUs	GAP for CHUs	CHAs Gap per existing CHUs
		Tononoka AP Dispensary	5	1	41			4
		State House Dispensary	3	1	25			2
		Kaderboy Dispensary	3	0	23			3
		Tudor S County Hospital	7	1	120			6
		Kingorani Prison Disp.	1	0	30			1
		TOTAL	**29**	**5**	**346**	**43**	**14**	**24**
6	Kisauni Sub-County	Mlaleo CDF health centre	6	1	60			5
		Junda dispensary	7	0	70			7
		Shimo main health centre	4	1	40			3
		Vikwatani CGTRH	7	1	70			6
		Utange dispensary	6	0	60			6
		Shimo borstal	1	0	10			1
		Maunguja	1	0	25			1
		Marimani	1	0	25			1
	TOTAL		**34**	**4**	**370**	**49**	**15**	**30**
	COUNTY		**209**	**26**	**2,322**	**262**	**53**	**184**

SUMMARY OF ISSUES AND CHALLENGES

1. **Staff establishment and distribution**
   a. Inadequate staff in most of the health facilities with most of the staffing levels far much below the norms and standards
   b. Staffing gaps and shortage of healthcare workers due various "push" and "pull" factors including migration, retirements, resignations, deaths, non-implementation of the approved establishment among other factors
   c. Vacant positions not filled for protracted periods of time
   d. Inequitable distribution of available health workforce
   e. Most Health facilities and units do not have approved staff establishment
   f. Some casuals have worked for a long time without being formally absorbed into the workforce
   g. Lack of clarity on the CHVs terms and conditions of service within the county public service structure as part of health workforce with defined tasks and performance accountabilities at Level 1
   h. Diverse and uncoordinated hiring practices and pay terms of contracting by development partners of health. This process is not aligned with government remuneration and salary structure for cadres of similar qualification. This presents a challenge after the funding and the contracts of such staff come to an end and the staff are to be absorbed by the county government.

2. **Human Resources Management**
    a. The HRM role in HRH is limited and slow to address HR matters
    b. HRH budget covers limited scope on personnel emoluments
    c. Lack of a county employee handbooks for health workers
    d. Inadequate Knowledge of HR policies and procedures
    e. Promotions, re-designations and upgrading of staff into various levels lacks a coordinated process that is clear and understood
    f. Political interference in HRM decisions on staff appointments, training and transfers
    g. Merit-based Human resources management practices are not formalized and are not adhered to consistently.
    h. Staff are not committed to work and presence at work is not a minimum requirement for productivity.
    i. Poor work environment that contributes to low staff morale and general dissatisfaction.
    j. Poor staff motivation due to unstructured performance recognition and awards.

3. **HRH Strategy and Practice**
    a. HRH strategic plan not linked to HRM planning, succession planning and other annual plans.
    b. Annual HRM work plan not informed by the CDOH staffing and training needs.
    c. Lack of succession plans to inform recruitment, promotions, training and development.
    d. Lack of staff retention strategy. Inability to attract and retain competent and motivated health workers compromises quality healthcare services.
    e. HR policy manual does not always used as a basis for HR decisions.
    f. CPSB HR policies not always adhered to.
    g. CDOH formal organogram not consistently used for HR planning, job descriptions, development and staff deployment.
    h. Staff establishment procedures not followed.
    i. Recruitment, deployment, transfer, leave management and promotion systems and policies not followed.
    j. Formal procedures stipulated for discipline, termination and grievance are not followed in a consistent manner.
    k. Work Council only meets during health workers' industrial actions and healthcare workers grievances are only attended under such circumstances.

4. **Compensation and payroll management**
    a. The current wage bill is above the budgetary guideline of 35% of all county revenues and is fiscally unsustainable and crowds out other important inputs for effective service delivery.
    b. Un-procedural payroll changes not in line with salary structure.
    c. Salary payment delays often leading to strikes by healthcare workers
    d. Delays and inconsistency in third party remittances including statutory and NHIF medical cover premiums.
    e. Varied salary and allowances structures both in allocation, variety and limits e.g., leave allowance for CBA, devolved vis a vis defunct local authorities' staff, laboratory staff uniforms, extraneous allowances for non-medical staff working beyond normal working hours and are on call whenever need arises etc.

5. **Training and Development**
   a. Lack of a county training and capacity development strategy
   b. Training offered is not based on a systematic training and capacity needs assessment neither linked to the County Health Department's key priorities.
   c. While there is a system for maintaining staff training and development of data which is stored manually, the data is not updated regularly.
   d. Ineffective supervision and mentorship of interns
   e. Haphazard implementation of training policy and budget allocation

6. **Employee welfare, occupational health and safety**
   a. The NHIF cover is not effective because payment of premiums is erratic thereby disrupting staff access to medical services.
   b. Lack of employee wellbeing initiatives including provision for rehabilitation services for employees should the need for such services arise
   c. Provisions for basic welfare services are not inconsistent

7. **HR Information Management system**
   a. All employee data is available and is up to date electronically in (HRIS), but low utilization of HRIS data in HR planning or forecasting or as data for decision making.
   b. Incomplete and not up to date personnel files.
   c. Lack of resources to develop systems for interconnectivity, data analysis or other data management.

8. **Performance management and tracking**
   a. Ineffective and inconsistently used performance management system
   b. The performance evaluation does not link rewards to performance nor weed out or sanction poorly performing staff.
   c. Limited staff recognition on performance

8.5 Task force commentary

The Task force recognizes the fact that human resource remains one of the greatest challenges of the county health system. Issues of inadequate health workforce establishment, poor work environment and chronic delays in salary payment, remittance of statutory deductions and positions left vacant for a long period of time remain matters of grave concern. These have cumulatively resulted in highly demotivated health workforce and poor service delivery and must be addressed as a matter of priority.

8.6 Recommendations

1. **Review and rationalize health workers' establishment and distribution**
   a. Review the establishment and determine actual needs using workload analysis to guide recruitments, promotions, staff deployments and transfers.
   b. Review the establishment of each facility independently and justify adjustment based on the staffing standard norms and the reality on ground. Some facilities have an expanded need based on the number of citizens served per day.
   c. Fill vacant positions promptly to ease the burden on overstretched workforce that has led to inefficient service delivery.
   d. Re-distribute staff according to the workload and specialization in a facility to reduce the length of time taken by resident to access health service.
   e. Evaluate the current casual employee status and immediately re-engage those who are currently under casual employment arrangements as appropriate under the County public service employment terms and conditions
   f. Undertake immediate re-designation of officers with relevant qualifications as this has no immediate financial implications
   g. Develop clear terms and conditions of services for the CHVs and consider regularizing the payment of CHVs stipend
   h. Develop county policy and guidelines on hiring and secondment of staff by partners to support the county government

2. **Strengthening Human Resources Management capacity**
   a. Strengthen the HRM capacity for effective management of HRH
   b. Depoliticize the HRM for HRH
   c. Adopt merit-based Human Resources Management practices
   d. All facilities with high volume workload and staff need to have functional HRM units to ensure that HR matters are expeditiously addressed. A qualified, competent and experienced People Manager should be placed in all Level 4 & 5 facilities and at the sub-county to coordinate Level 2 & 3 facilities.
   e. All Health facilities need to establish HRM Committees to enhance smooth co-ordination of HRH matters.
   f. CDOH needs to undertake comprehensive workload analysis of all work units to establish staffing requirements for all levels of health facilities and programs
   g. Strengthen HRH Supervision role to enhance accountability of the Human Resources at various levels
   h. HRH Unit needs to be Monitored by qualified Human Resource professionals.
   i. HRM budget needs to be enhanced
   j. Continuous Proficiency Development and payment of practicing licenses for all practicing HR officers in Health.
   k. Provide for fair promotion practices, training opportunities, a conducive work environment and competitive pay.
   l. Institute a clear induction & orientation process to include sensitization on HR polices and processes and general code of conduct.

m. Sensitize staff on disciplinary control, termination and grievance procedures.

n. Conduct a comprehensive Skills Inventory across the County Health Sector.

o. Conduct an inventory of staff who have stagnated and/or are due for promotions in order to compute the cost implication for the promotions and assess the feasibility possibility of promotions based on budget and make proposals to CPSB based on affordability giving priority to the staff who have stagnated for 10 and above years

3. Strengthening HRH planning and management policy and practice

a. Conduct a comprehensive health workforce and work environment assessment

b. Review and develop County HRH strategic plan aligned to the County HR strategic plan and annual work plans

c. Implement and adhere to the County HRM policy and Procedure Manual in HRM decisions.

d. Revive the Health Work Council to improve industrial harmony with trade unions by involving the union leaders in decisions affecting Healthcare Workers

e. Develop a County Job Descriptions and SOPs Manual for all health staffs in the County.

4. Strengthening HRH capacity

a. Conduct comprehensive training and capacity needs assessment for all Health workers including health system managers to establish training requirements for each cadre. This should be done at 2-year interval and its recommendations implemented.

b. Develop and implement county training and development plans and automated tracking system for the health sector

c. Undertake research and systematic review of the emerging medical protocols and mitigation measures

d. Optimize use of iHRIS platform for management of trainings.

e. Develop county training and development policy with clear budget allocation guidelines to guide training and development of health workers.

f. Develop policy guidelines and framework for engagement and linkages with the tertiary institutions and other training institutions.

g. Establish county training levy fund for training of health workers, pre- service and in-service trainings.

h. Establish a county co-ordination mechanism for non-government actors on training of county health workers

5. Ensuring wage bill sustainability and strengthening payroll management

a. Sustainability of the wage bill through viable interventions and policy directions. This can include:

   i. Exploring pay for service or performance related contracts for specialists.

   ii. Identifying the staff to be engaged on short contracts as per needs assessment.

   iii. Identity HRH for out sourcing purposes.

b. Carry out regular payroll audits and institutionalize payroll audits as a component of wage bill management

c. Timely payment of salaries and at policy level determine processing and remittance time-lines. Payment of salaries should be made not beyond 30th of the month and third-party remittance done in timely manner.

d. Develop and implement a formal procedure for payroll changes

e. Harmonize staff benefits across all staff cadres

6. **Enhancing employee welfare, occupational health and safety**
    a. Procurement of health insurance cover should be done in time. MCG should ensure that staffs obtain a reliable, effective and efficient staff medical insurance cover.
    b. Sensitize and train staff on benefits such as WIBA, last expense, life insurance among others
    c. Provision of psychosocial support and benevolent scheme
    d. Provide short term common training for all staff on matters of mental wellness, team building initiatives and general career advisory.
    e. Mainstream wellness and staff appreciation and recognition.
    f. Hold regular debriefs across facilities that can be 1-2 hours and let staff have opportunity to vent.

7. **Strengthening HR Information Management system**
    a. Establish Records Information Centre for the County to coordinate all HR information systems as well as act as custodian of all employee data under the HRH office as a unit.
    b. Continuously train HR professionals on IHRIS

8. **Strengthening performance management and tracking systems**
    a. Strengthening of staff performance management systems in Health Sector to enable the management to evaluate performance at institution and individual level.
    b. Implement rewards and sanction systems
    c. Employ an automated performance tracking system for the health workers.

CHAPTER 9: TOR 7: ASSESSMENT OF THE HEALTH MANAGEMENT INFORMATION SYSTEM FOR COUNTY GOVERNMENT HOSPITALS

9.1 Mandate of the Task force

The mandate of the Task force was to engage stakeholders including but not limited to the general public, healthcare workers, the National Health Insurance Fund (NHIF) to assess and recommend the implementation of a comprehensive Health Management Information System for all County Government Hospitals. Health information management system forms a very important component of the health system.

A well-functioning Health Information Systems (HIS) serves multiple users and a wide range of purposes including but not limited to generation, production, analysis, dissemination and use of reliable and timely data at all levels of the health system not just to identify problems and needs but more importantly, to enable decision makers make evidence-based decisions on policy matters including allocation of available resources optimally.[12]

The role of a well-functioning health information system is to ensure the production, analysis, dissemination and use of reliable and timely data by decision-makers at all levels of the health system. One of the objectives of the Kenya Health Policy (2014–2030) is therefore to plan, design, and install information and communications technology (ICT) infrastructure, and health information systems (HIS) for the management and delivery of essential healthcare.

9.2 The legal Framework

The Constitution of Kenya (2010) provides the framework for the management of the county health information management system. Article 35 (1) (3) provides that every citizen has the right of access to information held by the state and held by another person and requires the State to publish and publicise any important information to the public.

The Access to Information Act No. 31 of 2016 gives effect to Article 35 of the Constitution. Article 33 (1) (a) and (b) provides that every person has the right to freedom of expression including freedom to seek, receive or impart information or ideas. Article 46 (1) provides for the rights of consumers to the information necessary to gain full benefit from goods and services.

The Health Act No. 21 of 2017 provides the primary legal framework for the development and management of the national and county health information systems. In furtherance of the functions assigned to county governments under the Fourth Schedule of the Constitution, Section 20 (j) (m) of the Health Act vests in the county governments the responsibility for monitoring and evaluation and research for health; and reporting, according to standards established by law, on activities, development and the state of finance within the county health services.

Section 19 (5)(e) requires the County Director of health to prepare and publish reports and statistical or other information relative to the public health within the County.

[12] *WHO (2008), Health Information Systems: Toolkit on monitoring health systems strengthening, 2008.*

Sections 8, 9, 10, 12,13 and 14 of the Health Act, 2017 make extensive provisions on the responsibility for health information. Sections 103 and 104 of the Health Act recognizes E-health as a mode of health service and requires enactment of an enabling legislation provide for among other things - administration of health information banks including interoperability framework, data interchange and security; collection and use of personal health information; management of disclosure of personal health information; protection of privacy; business continuity, emergency and disaster preparedness; and health service delivery through M-health, E-learning and telemedicine.

Section 105 of the Health Act on health information systems, mandates the Ministry of Health to prescribe policy guidelines for establishment of an integrated comprehensive health information management system including an integrated comprehensive health information system relating to every county and in respect of county functions.

The Guidelines should further provide for the consolidation and harmonization of health information obtained from national and county health information system; the minimum standards applicable for establishment and maintenance of health information systems; a guide on the minimum indices to be captured by each county health information system; the mechanism for ensuring inter-connectivity between each county information system and the national system; the guiding principles for management and administration of health information banks; and any other information on health services, including sources of health financing, human resources available in health sector.

Section 105 also requires all healthcare providers to establish and maintain a health information system as part of the county health information system; and ensure compliance as a condition necessary for the grant or renewal of annual operating licenses. Section 105 (6) allows a county government to make necessary laws with regards to health information system as deemed appropriate for that county. Other relevant legislations include:

a. The County Government Act, 2012 that outlines the principles of citizen participation in county governance including timely access to information, data, documents, and other information relevant or related to policy formulation and implementation and the requirement of each county to provide clear input, output and outcome performance indicators, including the percentage of households with access to basic services contemplated under Article 43 of the Bill of Rights of the Constitution;
b. The Public Finance and Management Act, 2012 that provides for the general nature of the documents that the public may access and various national and local media through which a county government or any of its entities may publish and publicize documents or information relevant to the budget process;
c. The Public Procurement and Disposal Act 2015 that requires procuring entities to publicly avail procurement records after closure of proceedings, publicise notice of intention to enter into contract on websites and public notice boards and publish and publicise all contract awards;
d. The Data Protection Act No. 24 of 2019 that gives effect to Article 31(c) and (d) of the Constitution and makes provision for the regulation of the processing of personal data and the rights of data subjects and obligations of data controllers and processors; and
e. Kenya Information and Communications Act that makes provisions on electronic transactions and cyber security among others.

9.3 Assessment of the Mombasa County health management information system

The Mombasa County Health information system consists of Kenya Health Information System (KHIS2) formally, DHIS and several sub information systems that aid in relaying health information. KHIS2 is a web-based application that also produces reports of the aggregate community and facility routine data, vital events, survey or audit data, and of certain case-based or patient-based data. KHIS2 produces data aggregated at County level.

Data is usually collected and reported to KHIS from community, primary health facilities and hospitals. The data is uploaded at the facility level once the facility has rights, if a facility lacks rights their data is uploaded at the sub county by the health records and information officers who in addition ensure timely and quality data entry.

The KHIS data is generated through both manual and electronic systems with most private facilities using electronic medical records while a big number of public facilities still use manual systems. At the community level, CHVs report to the link health facility using household registers. At the health facility level, data are collected using cards and registers and then summarized and analysed together with data from the community level for onward transmission to the respective Sub-county for entry into KHIS2.

The County also runs a number of parallel information systems including Kenya EMR- for PLHIV patients, Medtronic system - for Diabetes and Hypertension patients, TIBU - for TB patients, and Fan-soft at CGTRH which is mostly used for patients billing. Mombasa County has 35 facilities implementing Kenya EMR, mostly supported by partners through USAID funds and majorly serving patients living with HIV (PLHIV) on ART.

The aim of the Partners supporting the Kenya EMR systems is to ensure all CCC facilities achieve improved outcome for all PLHIV patients through:

a. Digitization and automation of clinical care processes and decision support for HIV testing, prevention and treatment;

b. Adherence to Ministry of Health and PEPFAR guidelines;

c. Automated data generation for standard reports and line-lists and ease in generation of *ad-hoc* reports for custom needs; and

d. Automated data quality checks to improve on quality of data generated,

The Kenya EMR activities supported by MoH AFYA IT included EHR readiness facility assessment for integrated Electronic Medical Records (EMR) system in six facilities; delivery and installation of ICT, CPUs and networking equipment in 4 health centres, data migration in 35 facilities and installation of hospital-wide Kenya EMR+ system which was not in the initial agreement.

The MoH however, stopped transition to Kenya EMR (*only for PLHIV*) as an integrated EMR System due to its capacity to hold all round service delivery and also to pave way for national Health Digital Platform (HDP). In an assessment of the status of health management information systems and digitization of health facilities, the Task force made a number of observations as shown in *Table 8*.

Table 8: Assessment of the status of digitization of health facilities in Mombasa County

Focus	Key finding
System	• More than one system is being used from the facilities, while others don't. • Few Service Delivery Points (SDPs) are currently using the system in the facilities. • Lack of proper trainings for the users of the system. • There was no Manual Documentation of the system in most facilities. • Too many systems offering the same services to the clients. • Lack of harmonized/standardized modes of payment for services at service delivery points with some using mobile money services (*MPesa, Airtel etc.*), bank payment, banking agents while others accept cash payments.
Focus	**Key finding**
Infrastructure	• There are different internet providers within the facilities, and the internet connectivity is mostly unstable. • Desktops, laptops, printers, are available but not enough to most of the service points. • Most of the facilities do not have a dedicated room for server, • Lack of power backup Generators, and UPS in some of the facilities, • Most of the facilities do not have CCTV cameras within the premises, while others who have, are not enough. • Staff transferred/ moved with their laptops/computers or some cases refuse to handover (*weak asset management and security and handing over system*) • There is no ICT focal person within the facilities.
Challenges	• Lack of proper Network infrastructure and ICT equipment in the facilities. • Power outrages causes a challenge on digitization of health system and No back-up Generators in some facilities. • Lack of proper trainings on the use of the system. • Lack of security for the sensitive equipment's. • Lack of funds to go completely paperless in some service points within the facility. • Insecurity – lack of security personnel and perimeter walls in most facilities. • Poor drainage and storm water management systems in some health facilities such as Maweni facilities • Shortage of staff, some facilities lack personnel to oversee the project • Lack of space In some of the facilities.

Overall, the Mombasa County health information system remains weak and fragmented. The existing public HMIS system are either an EMR or an ERP system or both, not interoperable, program-based and supported by development partners. The partner supported systems are however, not sustainable on the long-term. The HIS landscape is characterized by multiple and parallel information systems; the weak health information infrastructure; limited and stretched human resource and technical capacity; weak system integration and data linkages from various sub systems to the KHIS2; low investment in HIS; unreliable power and internet services; poor information culture that does not spur demand for information; and inconsistent use and application of information and communications technology (ICT) enabled solutions (*eHealth, HER/EMR and mHealth*). The challenges expressed by the stakeholders that limit the progress and successful implementation and integration of HIS in the health system are summarized as follows:-

SUMMARY OF VIEWS/FINDINGS

1. **On health system HIS capacity**
   a. Low public investment in HIS. Many health information systems are partner driven and not inter-operable leading lack of data accountability. The term "interoperability" describes the ability of different information systems, devices and applications ('systems') to access, exchange, integrate and cooperatively use data in a coordinated manner, within and across organizational, regional and national boundaries, to provide timely and seamless portability of information and optimize the health of individuals and populations across all levels
   b. Limited human resource and technical capacity especially at the community and primary healthcare facilities level to utilize electronic based system;
   c. Lack of integrated HMIS and mechanisms for data and information sharing across different programmes and sectors
   d. Fragmentation of health information systems at county health system, health facility and community health system levels

2. **On facility-based HMIS Capacity**
   a. Lack of HMIS staff in some facilities.
   b. Limited installation of HMIS at service points.
   c. Lack of hospital management information systems integration with other systems.
   d. Lack adequate budget allocation for digital transformation making implementation of HMIS on a full scale difficult.
   e. Most of the HMIS in place do not meet MoH reporting standards.
   f. Lack of ICT enabled follow up, feedback and referral solutions.

3. **On ICT support and infrastructure**
   a. Lack of ICT staff in most health facilities.
   b. Inadequate computers, printers and copiers
   c. Lack of, and/or unreliable Internet and Local Area Network (LAN)
   d. Inadequate basic ICT-skilled staff
   e. Unstable power supply with most health facilities having no power back-up.

4. **On Data management**
   a. Inadequate technical skills in key areas such as data management
   b. Data management in health facilities is still predominantly manual. Manual systems are overburdening to staff with too many tools for data.
   c. Fragmentation of data management systems
   d. Lack of data quality assurance capacity leading to loss of data, incomplete and inaccurate data.
   e. Lack of universal system for data collection ranging from paper-based data collection to automated/digitized platform
   f. Weak data linkages from various sub systems to the KHIS2;
   g. Low data mining capacity to avail useful information for decision making.

5. **On monitoring and evaluation**
   a. Lack of integrated M&E framework for health
   b. Inadequate system capacity for timely reporting; production of disaggregated data and use of data for policy and planning; and for monitoring and evaluation of trends in health services and outcomes
   c. Inadequate funding for M&E
6. **Research and knowledge management**
   a. Lack of funding for conduct operational research.
   b. Lack of clear institutional mechanism for research at the county level

9.4 Task force commentary

The Task force recognizes the significance of a well-functioning health information system in ensuring effective service delivery, evidence-based decision making and functionality of the health system. While the county health department with the support of the MoH and development partners have made considerable investments to strengthen health information systems across the spectrum, the county health information system remains fragmented with data and information stored in many different formats across various systems and locations thereby making access, sharing, and analytics difficult or impossible to achieve and to support effective decision-making. The general lack of an integrated and effective county HIS has therefore resulted in a significant gap between policy and practice thus making it difficult to connect, for example, the resources invested to results achieved or not achieved. The Task force therefore advocates for the consolidation of resources and efforts in health information systems including M&E and operational research across the county health system and service delivery levels; and for increased budget allocation to strengthen data collection, information generation, analysis and utilization of health information at all levels of the system and to enhance the culture and practice of evidence-based decision making. Appropriate investment in, and consistent use and application of ICT enabled digital solutions will also be critical in enhancing the efficiency and functionality of the health information system and its application to decision making.

9.5 Recommendations

1. **Establish and operate a well-functioning integrated county health information system and implement county digital health transformation strategy:**
   a. Establish and operationalize Mombasa County Integrated Health Management Information System integrating public health services and disease surveillance mapping
   b. Establish an interconnected Hospital Management Information/EMR/EHR System across all county health facilities linked with KHIS to manage the end-to-end patient journey, allow ease of capture of data and enable effective tracking of patients and indicators across facilities. The HMIS system identified should also have provision for grievances registration and feedback.
   c. Train Healthcare Workers on use of EMR and health digital platform
   d. Promote the use of scalable, affordable, open access software systems and work with collaborations to develop and use common health information architecture, standards, guides, tools and solutions.
   e. Optimize the use and application of ICT enable solutions (*e-health, m-health, e-referrals, telemedicine/tele health and other personalized health mobile apps*)

2. **Increasing budget allocation for HMIS and ensure sustainable financing for HIS and Digital Health transformation:**
    a. Develop and implement Mombasa County digital transformation master-plan
    b. Establish a multi-sectoral coordination mechanism to:
        i. Coordinate and oversee county HIS activities and investments
        ii. Promote peer-to-peer networking and knowledge exchange
        iii. Coordinate and harmonize development partners and national government investments in support of county and health facility health information systems.
    c. Provide adequate reporting tools for level one services as well as using eCHIS (*Electronic Community Health Information System*).

3. **Optimize the use of ICT and ensure infrastructure readiness:**
    a. Set-up a full ICT infrastructure in all the facilities and ensure at least one ICT person within the facility to optimize the use of information and communication technology (ICT) to facilitate the generation of accurate and timely data; improve the availability, completeness, timeliness, quality, and use of data for decision-making in health; and minimize the burden of data collection, analysis and reporting
    b. Procure and install appropriate computer facilities in all county public health facilities
    c. Ensure Fibre optic backbone connectivity to all health facilities to ensure effective communication between the health facilities and the county data centre for HMIS operations.
    d. Install Local Area Network at every service point and relevant offices in the health facilities and ensure each service point and critical offices are connected to the local nerve centre.
    e. Install internet bandwidth connectivity to each health facility
    f. Hire necessary ICT staff and use shared technical capacity deployment model to optimally and cost-effectively support all the health facilities and community health resource centres
    g. Install CCTV surveillance, biometrics, access control and security in all health facilities, giving priority to levels 4 and 5 in the immediate.
    h. Establish a central county data centre linked to primary and secondary data centres at levels 3, 4 and 5 and public health and environmental programs and services to ensure redundancy, business continuity and data recovery should the primary data centres fail

4. **Strengthen and build human resources for HIS capacity**
    a. Ensure adequate and skilled human resources for HIS and digital health including ICT personnel at county, sub county and health facility levels. The following skills are essential:
        i. Health information officers to capture data from service points, manage and analyse health and medical records and data and maintaining record safety and confidentiality etc.
        ii. Systems Administrators to manage the server infrastructure, storage, and processing systems.
        iii. Network Administrators to manage the switching, transmission, internet, and data connectivity.
        iv. Database Administrators to manage the databases, data storage, data analytics and interfacing with the HMIS.
        v. Applications Developers to develop, customize or extend the functionality to applications.

vi. Data Analysts to program intelligence and glean useful insights from the HMIS operations to guide decision in healthcare and management.

vii. Information security and cyber-security personnel to secure the infrastructure, systems, services, and data in the backdrop of sensitive healthcare data and heightened cyber-security challenges.

5. **Establish an integrated County Health Sector M&E framework and mechanisms for regular progress and performance reviews and assessments:**
   a. Establish an integrated County health sector monitoring and evaluation (M&E) framework based on Three-Ones principle of one plan, one budget and one monitoring and evaluation framework.
   b. Strengthen Public and environmental health data collection and reporting and digitize the data collection tools
   c. Strengthen mechanisms of regular reviews and analyses to assess progress and performance against national and county health sector related priorities including progressive realization of the right to health guaranteed under Article 43 of the Constitution.

6. **Strengthen operation research and knowledge management**
   a. Establish/strengthen the county health research and knowledge management unit
   b. Establish/strengthen inter-agency technical working group on research to effectively co-ordinate and oversee health research activities in the county and enhance collaboration of health research groups
   c. Establish a county health research and knowledge management platform for dissemination of information and research findings, sharing best practices and promotion of knowledge exchange and learning
   d. Build decision makers and healthcare workers' capacity in operational research and evidence based practice and decision making
   e. Ensure adequate funding and budget allocation. leverage on research grant opportunities for health research and knowledge management activities.
   f. Strengthen the research function of Coast General Teaching and Referral Hospital and promote collaborative research with research institutions.

CHAPTER 10: TOR 8: STRATEGIES FOR ADDRESSING DISEASE BURDEN AND PATTERNS

10.1 Mandate of the Task force

The mandate of the Task force was to engage stakeholders including but not limited to the general public, healthcare workers, the National Health Insurance Fund (NHIF) to assess and recommend strategies on addressing disease patterns. The Health Act, No. 21 of 2017 defines disease as any physical or mental condition that causes pain, dysfunction, distress, social problems or death to the person afflicted or similar problems for those in contact with the person. Disease burden is the impact of a health problem on a given population, and can be measured using a variety of indicators such as mortality, morbidity or financial cost. Mombasa County and Kenya as a whole is facing a triple burden of communicable diseases (spread through contact with infected agents or carriers), non-communicable diseases (*lifestyle and environmental illnesses*) and neo-natal diseases (*affecting infants under one-years-old and are usually vaccine preventable*). Kenya is also undergoing an epidemiological transition marked by decline in morbidity and mortality due to communicable conditions, and an increase in the burden of non-communicable diseases (NCDs).

10.2 The legal Framework

The Health Act No. 21 of 2017 and Public Health Act Cap 242 provide the primary framework for addressing disease burden in Kenya. The Health Act, 2017 section 15 (i) vests in the national Government the responsibility to put in place policy intervention measures to reduce the burden of communicable and non –communicable diseases, emerging and re-emerging diseases and neglected diseases. Section 19(5) (d) (f) of the Health Act, 2017 vests in the County Director of health the duty to promote the public health and the prevention, limitation or suppression of infectious, communicable or preventable diseases within the County; and report periodically to the Director-General for health on all public health occurrences including disease outbreaks, disasters and any other health matters. Section 20 (h) requires the county government in furtherance of the functions assigned to it under the Fourth Schedule of the Constitution to maintain standards of environmental health and sanitation as laid down in applicable law.

Part VIII Section 68 of the Health Act No. 21 of 2017 provides the framework for the promotion and advancement of public and environmental health including measures to promote health and to counter influences having adverse effect on the health of the people; interventions to reduce the burden imposed by communicable and non-communicable diseases and neglected diseases, especially among marginalized and indigent population; interventions to promote healthy lifestyles; general health education of the public; programme to advance reproductive health, maternal and neo-natal and child health, maternal nutrition and micro nutrient supplementation; and measures for the reduction of disease burden arising from poor environmental hygiene, sanitation, occupational exposure and environmental pollution; the reduction of morbidity and mortality of water-borne, food-borne and vector transmitted diseases, and mitigate the health effects of climate change.

The Public Health Cap 242 provides for the notification of infectious diseases; prevention and guarding against the introduction of infectious disease into Kenya from outside; control and prevention of diseases of international concern including prohibition, restriction or regulation importation into Kenya of any animal, or article which may introduce any infectious disease; promoting the public health and the prevention, limitation or suppression of infectious, communicable or preventable disease within Kenya; promoting and carrying out investigations in connection with the prevention or treatment of human diseases; and preparing and publishing reports or other information relative to the public health.

10.3 The disease burden in Mombasa County

Mombasa County faces several health challenges including high burden of both communicable and non-communicable diseases. Many of the diseases that account for a large part of the disease burden in Mombasa County are primarily associated with infectious diseases, reproductive health, and childhood illnesses such as HIV/AIDS, tuberculosis, upper respiratory tract infections, hypertension, diabetes, cancers and malnutrition as well as maternal, newborn and child morbidities and mortality. Just eight diseases and conditions account for the largest proportion of all deaths. These include TB, HIV/AIDS, diarrhoeal diseases, vaccine-preventable diseases of childhood, malaria, respiratory infections, maternal conditions, and neo-natal deaths. Neo-natal diseases, together with communicable, maternal and nutritional diseases, account for 63% of deaths in the country, whereas NCDs account for 27% and injuries for 10%.[13] The prevalence of the three major communicable diseases in the county stands at 4.1% for HIV/AIDs, 700/100,000 for TB and 8% for malaria.[14]

About 80% of all hospital attendance in Mombasa are attributed to preventable diseases and at least 50% of these preventable diseases are linked to poor water, sanitation and hygiene. The top five conditions affecting the under five years old in Mombasa include upper and lower respiratory tract infections, diarrhoea, diseases of the skin and confirmed malaria cases. Similarly, the top five conditions affecting the above five years old include upper and lower respiratory tract infections, UTIs, diseases of the skin and diarrhoea. Notable STI trends is on the decrease from 11,065 (2017) to 8,629 in 2021 with a positive decline of 22%. Poor hygiene, overcrowding, poor waste disposal and environmental pollution have led to increased incidences of diarrhoeal and respiratory diseases, contributing to the breeding of vectors and infectious micro-organisms which in turn, has often led to the sporadic outbreak of communicable diseases. Non-communicable diseases such as hypertension, oncology cases, diabetes, drug and substance abuse are on rise. Hypertension conditions are now among the top ten causes of morbidity. There is also an increase of diabetes cases from 10,723 (2017) to 22,627 in 2020 with a slight decrease of 18022 (2021).[15] According to the STEPS survey 2015, NCDs accounted for over 55 percent of hospital deaths in Kenya while more than 50 percent of all the hospital admissions were due to NCDs.[16] Drug and substance abuse is high with only three functional drug rehabilitative centres and eight outpatient detoxification centres in the county serving over 600 clients. The burden of violence and injuries is high associated with risky cultural practices and beliefs, road accidents and domestic and gender-based violence. The stigma associated with gender-based violence (GBV) and culture prohibits reporting to relevant authorities for relevant actions to be taken.

[13] *Beth Waruguru Hinga (2021), The Terrible Three: Easing The Triple Burden of Disease in Kenya on March 2, 2021* **https://www.borgenmagazine.com/triple-burden-of-disease/**

[14] *County Government of Mombasa (2018), Second Health Strategic and Investment Plan (CHSIP II) 2018 – 2022, County Department of Health*

[15] *KHIS 29th October, 2022.*

[16] *Dr. Kiarie Helen, Dr. Gatheca Gladwell, Ngicho Calestus and Dr. Elizabeth Wangia (2019), Policy Brief Lifestyle Diseases – An Increasing Cause of Health Loss, MOH,* **https://www.health.go.ke/wp-content/uploads/2019/01/Revised-Non-Communicable-Disease-Policy-Brief.pdf**

The key health determinants include unemployment and job security, lack of social protection, poor living conditions, the literacy levels of women, poor nutrition and food security, alcohol and substance abuse; unsafe sex, poor access to safe water and adequate sanitation, lack of proper housing, basic amenities and environment, poor roads and infrastructure, discrimination and gender-related determinants among others. Most of the communicable diseases are attributed to unhealthy living conditions and lack of access to clean and safe water and sanitation which are identified as among the leading risk factors and contributors to high morbidity burden (DALY) and mortality (deaths).

10.4 Task force commentary

The Task force recognizes the fact that despite some improvements in health indicators, the disease burden in Mombasa County is still unacceptably high yet the major causes of the disease burden, ill health and premature deaths can be prevented and controlled through simple cost-effective interventions. While public and environmental health practitioners and policy-makers have a responsibility to ensure the health of all, investment in a broad package of strategies for health promotion, prevention and control of diseases remains low priority. It is therefore imperative that the county health sector expenditure be re-purposed to focus more on interventions and services that enhance prevention and control of the spread of diseases and reduce health inequities that lead to differences in health outcomes between individuals and populations within the county.

The Task force further noted the issue of lack of inter-agency and stakeholder coordination mechanisms and disharmony between different county departments in the control and management of environmental health risks such as effluent and garbage management. It was pointed out that the Department of Health faces a lot of challenges in enforcing the law when it is the county government departments and agencies that fail to execute their mandates. This problem could be easily addressed if the "***County Inter-Agency Coordination Committee***" (CICC) envisaged under Section 23 of the Mombasa County Environmental Health and Sanitation Act 2017 was established. It would also ensure a coordinated, efficient, effective and consultative approach to environmental health and sanitation concerns and other matters as they may arise.

10.5 Recommendations

To effectively address the disease burden and patterns in Mombasa County, the Task force advocates for prioritisation of, and increased budget allocation for effective prevention, management and control of the high burden of communicable, non- communicable and neo-natal diseases in the County. The Task force therefore proposes a broad package of preventive, promotive and therapeutic health strategies to cost-effectively:

a. Prevent diseases from occurring and thus reducing the incidence (*new cases*) of disease;

b. Promote healthy lifestyles and practices to keep people healthy and empower individuals and communities to engage in healthy behaviours; and

c. Treat, mitigate, or postpone the effects of disease thereby reducing the case fatality rates or reducing the disability or morbidity associated with a disease.

1. **Ensure effective prevention, management and control of communicable, non- communicable and neo-natal conditions:**

   a. Increase child immunization coverage and reduce dropout rate through, good documentation and increased immunization service hours

   b. Create demand for immunization services through outreaches and increased immunizing facilities

c. Promote vaccine initiatives to protect the population against infectious diseases including COVID-19, Flu, HPV, tuberculosis (TB) or HIV infection, pneumonia

d. Promote regular provision of high-protein/calorie diets or supplementation to individuals with specific micro-nutrients to reduce calorie and protein deficiencies and specific deficiencies in micro-nutrients such as iron, folate, zinc, iodine, and vitamin A.

e. Scale-up access to maternal and neo-natal health services before, during and after pregnancy. This should include family planning, treatment of infections, such as syphilis and malaria and ensuring access to good nutrition, including micro-nutrients, antenatal monitoring and care, and access to skilled care at the time of delivery and post-partum and promotion exclusive breastfeeding and care practices

f. Strengthen community based MNCH programs and improve the performance of the health system in provision of RMNCH and care services

g. Increasing ANC uptake through health talks in the facilities and at community levels on the importance of early Focused Antenatal Care (FANC), identification and referral of ANC mothers from the community and strengthening of MNCH.

h. Strengthen integrated disease surveillance and health information systems for complete and timely reporting of communicable and non-communication disease incidences

i. Design and implement NCDs awareness and behaviour change campaign on risk factors, screening and treatment programs.

j. Carry out regular screening for non-communicable diseases to enhance access and early detection and management

k. Build capacity of health workforce and establish specialized NCDs clinics.

l. Strengthen nutrition interventions towards NCD prevention and control

m. Prioritize management of alcohol, drug and substance abuse in the County

n. Promote integration of injury prevention programs such as road traffic accidents, drowning, fires, poisoning, and interpersonal violence into public health programs to reduce injuries that may result into deaths and disabilities.

2. Ensure effective promotion of healthy lifestyles, practices and behaviours:

a. Strengthen health education and social behaviour change communication programmes including:

   i. Educating communities, children or mothers about the causes of the disease and how to prevent it;

   ii. Promoting adherence to long-term treatment such as for HIV, TB and NCDs; and

   iii. Developing effective community participation in programmes that need broad coverage to maximize the effects of immunization or drug distribution, require people to recognize disease symptoms for early treatment, necessitate active co-operation in home improvements or insecticide programmes, involve direct action and responsibility in deploying vector, or intermediate host, traps and need community efforts for environmental improvements such as developing and maintaining improved water supplies or better disposal methods for faeces.

d. Design and implement an integrated health, nutrition and wellness campaign program to promote healthy lifestyles and practices with respect to diet and promotion of healthy eating behaviours, physical activities, cessation of smoking, and the control of metabolic disorders.

e. Strengthen advocacy, communication and social mobilization for disease prevention and control.

3. **Strengthen the county health system capacity and public and environmental health function to among other things:**
    a. Design and implement interventions to reduce exposure to environmental, occupational and biological risk factors such as reduction in air pollution, advocate for recreational public spaces
    b. Enforce national and county public health laws, International Health Regulations and legal restrictions including food labelling and tobacco and alcohol control
    c. Promote safely managed water, sanitation and hygiene across the service chain
    d. Tackle indoor or outdoor air pollution or involving the disposal of contaminants such as pesticides or heavy metals
    e. Enforce and implement vector and vermin control measures
    f. Promote and enforce food and water safety regulations
    g. Support drugs and substance abuse control and rehabilitation measures
    h. Support reproductive health and sexual gender-based violence control and management measures
    i. Support communities to participate in improving their living environment and eliminating vector breeding sites and screening improvement for reducing human-vector contact
    j. Promote multi sectoral coordination, intergovernmental relations and sustainable partnerships with both national, county and international organizations for the prevention and control of communicable and non-communicable diseases
    k. Design and implement training and capacity building program for healthcare workers and CHVs on communicable and non-communicable diseases including mental health disorders prevention and control.

4. **Strengthen therapeutic prevention and control interventions to treat, mitigate, or postpone the effects of disease to reduce the case fatality rates or reducing the disability or morbidity associated with a disease. The key strategies include:**
    a. Carrying out mass treatment of the populations or the targeted treatment of identifiable subgroups (*such as school-age children*) to promote the prevention of infections (prophylaxis) or diseases consequent to infection;
    b. Strengthening mechanisms for case finding and treatment of infectious diseases such as TB, HIV and leprosy to reduce morbidity and mortality;
    c. Implementing combination of education/behaviour change measures to ensure regular, often daily, use of medicines for controlling of chronic diseases such as HIV, TB, cardiovascular diseases and many cancers.
    d. Carrying out screening of communities to identify and assess cases to determine the stage of the disease and possible attendant complications that are likely to require a variety of laboratory tests and develop a long-term treatment and assessment plan.

5. **Establish/strengthen operations research and integrated disease surveillance capacity:**
    a. Strengthen integrated disease surveillance systems to monitor disease trends.
    b. Strengthen community-based disease surveillance, reporting and referral systems

c. Strengthen public health department's capacity in operations research to:
    i. Improve understanding of disease biology, intervention planning and implementation
    ii. Assess economic feasibility of new prevention and control strategies
    iii. Help inform decisions related to prevention and disease screening including the design of new interventions
    iv. Identify opportunities for cost reductions in routine processes and help optimize the delivery of existing interventions
    v. Strengthen health systems and support decision-making at all levels of disease prevention, control and management; and
    vi. Inform policy and contribute to effective and efficient infectious disease management and improved health outcomes.
g. Establish CGTRH Utange Field Hospital to function as the County Infectious Diseases Hospital and Research Centre
h. Establish a special fund for public health surveillance programmes including research, epidemiological investigations or surveys of people, animals or vectors to determine the existence, prevalence or incidence or the likelihood of a possible outbreak of infectious diseases as envisaged under sections 41 to 57 of the Mombasa County Environmental Health and Sanitation Act, 2017.

CHAPTER 11: TOR 9: ACHIEVING AFFORDABLE AND ACCESSIBLE UNIVERSAL HEALTHCARE IN THE COUNTY OF MOMBASA

11.1 Mandate of the Task force

The mandate of the Task force was to engage stakeholders including but not limited to the general public, healthcare workers, the National Health Insurance Fund (NHIF) to assess and formulate lasting solutions towards achieving universal healthcare that is affordable and accessible in the County of Mombasa. The Sustainable Development Goals (SDG) target 3.8 focuses on achieving Universal Health Coverage, including financial risk protection, access to quality essential health-care services and access to safe, effective, quality and affordable essential medicines and vaccines for all. To be realized universal health coverage requires a re-orientation of health systems towards a strong and people-centred primary healthcare (PHC).

11.2 The legal Framework

The Constitution of Kenya, Health Act 2017 and Public Health Act Cap 242 provide the primary legal framework for ensuring universal health coverage. Article 43 (1)(a) (2) guarantees every person the right to the highest attainable standard of health which includes the right to healthcare services, including reproductive healthcare and emergency medical treatment. In addition, Articles 42 and 43(1)(b)(c)(d) guarantees every person the right to a clean and healthy environment; accessible and adequate housing and reasonable standards of sanitation; adequate food of acceptable quality; and clean and safe water in adequate quantities.

Articles 21(1)(3) and 20(5) (b) of the Constitution vests in the State the fundamental duty to observe, respect, protect, promote and fulfil the right to health and requires the State in providing health services and allocating resources to address the needs of vulnerable groups within society and to give priority to the widest possible enjoyment of the right to health having regard to prevailing circumstances, including the vulnerability of particular groups or individuals such as women, children, persons with disabilities, the elderly, minority and marginalized groups. Article 22 of the Constitution gives every person the right to institute court proceedings claiming that his/her health right has been denied, violated or infringed, or is threatened and requires the court to adopt the interpretation that most favours the enforcement of the right. Part II (2) of the Fourth Schedule to the Constitution vests in the county government county health services functions.

The Health Act, 2017 reiterates the constitutional standard of the right to health contemplated in Article 43 and Part 3 of the Bill of Rights on specific application of rights of vulnerable, minority and marginalized groups including children, youth, persons with disabilities and the elderly (Articles 53-57). The Act aims to among other things ensure physical and financial access to healthcare including the provision of a health service package addressing promotion, prevention, curative, palliative and rehabilitation at all levels of the healthcare system. Section 5, 6, 7 and 8 of the Health Act sets out the standard for the realization of the right to the highest attainable standard of health which includes progressive access to promotive, preventive, curative, palliative and rehabilitative services; the provision of free and compulsory vaccination for children under five years of age and maternity care; reproductive healthcare; emergency treatment and health information. Section 6(3) of the Act places an obligation on the State to ensure provision of healthcare in legally recognized health facilities by trained health professionals and to provide enabling environment consisting of the minimum human resource, infrastructure, commodities and supplies as defined in the norms and standards.

The National Hospital Insurance Fund (Amendment) Act No. 1 of 2022 provides for the ensuring universal health coverage through social health insurance. Section 5(1) (g) of the principal Act as amended provides that one of the objects of the NHIF is to facilitate attainment of Universal Health Coverage with respect to health insurance. Sections 3 and 15(1B) of the Principal Act as amended provides the framework for the National government through monies appropriated by the National Assembly to cater for the insurance of indigent and vulnerable persons and hold the national government liable as a contributor to the Fund on behalf of the indigent and vulnerable persons.

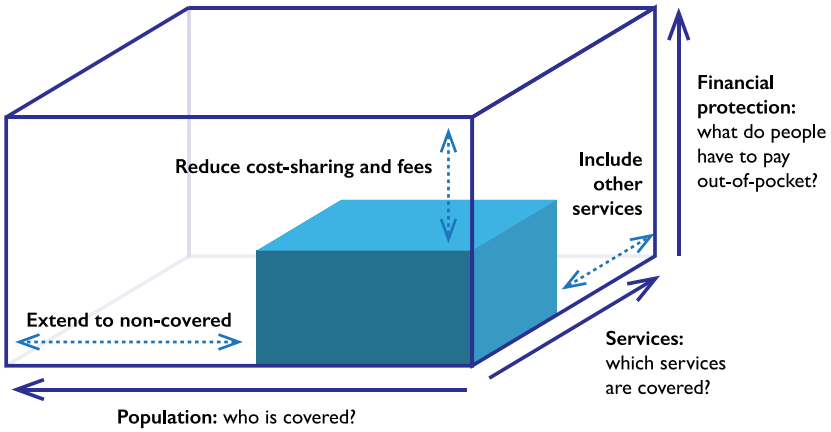
The NHIF (*Amendment*) Act, 2022 defines "indigent" as a person who is poor and needy to the extent that the person cannot meet their basic necessities of life. It defines vulnerable person as a person who is in need of special care, support or protection, including the orphaned and vulnerable children, widows or widowers, person with disability, elderly persons or indigent due to a risk of abuse or neglect and who has been identified as such by the relevant government body. The NHIF Amendment Act, 2022 makes contributions mandatory for citizens aged 18 years and above, except those listed as dependants.

11.3 Essential elements and principles of universal health coverage (UHC)

A resolution at the 58th World Assembly in 2005 encouraged the countries of the world to embed UHC in their health systems, and the World Health Report (2010) proposed improved financing for healthcare to achieve this goal.[17] WHO has defined universal health coverage (UHC) as ensuring that all people can use the promotive, preventive, curative, rehabilitative and palliative health services they need, of sufficient quality to be effective, while also ensuring that the use of these services does not expose the user to financial hardship.[18]

Universal Health Coverage implies access to the full range of quality health services they need, when and where they need them, without financial hardship.[19] It covers the full continuum of essential health services, from health promotion to prevention, treatment, rehabilitation and palliative care. The main concepts of UHC include population coverage, range of health services provided, and out-of-pocket expenditure as shown in the *figure 3* below.[20]

Figure 3: The three dimensions of Universal Health Coverage.



Source: M.R. Mathur, D.M. Williams, K.S. Reddy and R.G. Watt (2015), Universal Health Coverage: A Unique Policy Opportunity for Oral Health, Journal of Dental Research 2015 Mar; 94(3 Suppl): 3S-5S. doi: 10.1177/0022034514565648

[17] *World Health Organization (WHO). 2010. The World Health Report: Health Systems Financing: The Path to Universal Coverage. Geneva (Switzerland): WHO*

[18] *World Health Organization (WHO). 2010. The World Health Report: Health Systems Financing: The Path to Universal Coverage. Geneva (Switzerland): WHO*

[19] *WHO, Universal Health Coverage. https://www.who.int/health-topics/universal-health-coverage#tab=tab_1*

[20] *M.R. Mathur, D.M. Williams, K.S. Reddy and R.G. WattUniversal Health Coverage: A Unique Policy Opportunity for Oral Health, Journal of Dental Research 2015 Mar; 94(3 Suppl): 3S-5S. doi: 10.1177/0022034514565648*

Kenya's attempts to implement UHC dates back to 2004 when the government considered mandatory health insurance with a package of care defined in 2004, but which was never adopted.[21] In line with the Constitution of Kenya 2010, the Kenya Health Sector Strategic and Investment Plan (KHSSP) 2014–2017 outlined the Kenya Essential Health Package (KEPH) as an 'obligation of the health sector towards realization of the constitutional right to health'.[22]

Using KEPH, the Kenya Universal Health Coverage Essential Benefit Package (UHC-EBP) was developed and organised into two broad categories of services namely public and community health services (*e.g., health promotion*); and facility-based services. The facility-based services were divided into the following clinical areas: reproductive, maternal, newborn, child and adolescent services, management of non-communicable diseases and mental health services. Each clinical area was linked to "a clinical protocol, guidelines and in some cases a policy that described what the beneficiary was entitled to (service entitlement, and conversely, what the provider was required to deliver (*service requirement*)."[23] The UHC-EBC was also linked to the Kenya Essential Medicines List (2016), the Kenya Essential Medical Supplies List (2016) and the World Health Organization Model List of In Vitro Diagnostics (2018).

The UHC-EBP was piloted in four counties, namely Kisumu, Isiolo, Machakos and Nyeri was launched in December 2018 and ended in December 2020. The four counties were selected on the basis of high prevalence of non-communicable and communicable diseases, high maternal mortality, high road traffic injuries, and high population density. The purpose was to test the fitness for purpose of the UHC-HBP and the accompanying planned implementation strategy. The objectives of the UHC programme were:- to ensure that Kenyans have access to an explicit unified progressive health benefit package; expand the population under universal health insurance coverage; increase the availability and coverage of quality essential interventions; ensure financial risk protection for Kenyans with a special focus on the poor and the vulnerable groups; and ensure adequacy of health resources for the delivery of health services.[24] The funding for the pilot phase of the UHC-EBP was through input financing to cover different categories of expenditure such as human resources, commodities, equipment and expansion of health infrastructure.[25]

Using UHC-EBP as a foundation, various additional packages were developed and delivered under National Hospital Insurance Fund (NHIF):

i. SUPA Cover;

ii. Health Insurance Subsidy for the Poor (HISP),[26] a scheme which seeks to cover Kenya's 9 million indigents using the same HBP as SUPA cover;

iii. ***Linda Mama***, a programme to provide free maternal services;

iv. The Civil servant's scheme which provides medical insurance cover for civil servants; and

v. ***EduAfya***, a scheme which provides medical insurance cover for public secondary school students.

[21] *Künzler, Daniel. 2016. "The Politics of Health Care Reforms in Kenya and Their Failure." Social Policy 1.*

[22] *Ministry of Health (2021), "Policy Brief on Universal Health Coverage Benefits Package 2020 DRAFT (Unpublished)."*

[23] *UHC Health Benefits Package Advisory Panel (2018), "Report on the UHC Essential Benefits Package."* ***https://centerforglobaldevelopmy.sharepoint.com/:w:/g/personal/lregan_cgdev_org/ETz3vfSjOiFPhu1MlEDPI5sBkz20Uu9IJWjaBuTqaaVj9_w?rtime=LCJOwxJu2Ug.***

[24] *People's Health Movement Kenya (2020), UHC Survey Dissemination report, DECEMBER 10, 2020*

[25] *Y-Ling Chi and Lydia Regan (2021), The Journey to Universal Health Coverage: How Kenya Managed the Inclusion of Disease Programmes in its Health Benefits Package, Centre for Global Development (CGD), Case Study, November 2021*

[26] *International Social Security Association (ISSA) (2014), Health Insurance Subsidy Programme for the Poor, Older Persons and Persons with Severe Disabilities, International Social Security Association (ISSA), 2014.* ***https://ww1.issa.int/gp/162201***

In addition to the packages ran by NHIF, many disease programmes also developed their own HBP; e.g., HIV, malaria and tuberculosis (TB). These programmatic areas receive substantial external funding and their corresponding HBPs are often developed in collaboration with development partners.

The NHIF SUPA Cover is based on payroll deductions for formal sector employees (*mandatory health insurance*), voluntary insurance (*Kshs. 500 per month for principal members and beneficiaries*) and government contributions to cover indigents under the HISP. The health benefits package (HBP) entitlements include outpatient services, inpatient services, maternal care, reproductive health services, renal dialysis, overseas treatment for specialised surgeries, rehabilitation for drugs and substance abuse, all surgical procedures including transplants, emergency road evacuation services radiology imaging services, cancer treatment.[27]

Following the definition of UHC-EBP, a decision was taken to further refine the package by developing a harmonized health benefits package combining the previously existing HBPs, namely the KEPH; Makueni Care, a health financing scheme launched in 2016 to provide free access to a package of services in public hospitals;[28] NHIF SUPA Cover; UHC-EBP; and the Kenya Essential Medicines List (*KELM revised 2019*). The harmonized HBP was developed using the criteria of equity, disease burden, quality of care and vulnerability to catastrophic health spending.

The new Kenya Harmonized HBP like the UHC-EBP is organised into two categories, namely (i) curative health services (*facility-based*) and (ii) public health, preventive and promotive health services (*community-based*). The harmonized package is considered the vehicle for the delivery of Kenya's UHC policy. It aims to progressively expand health insurance coverage among Kenyans, in particular among the poor and vulnerable groups; expand the UHC scheme benefit package; enhance financial risk protection, in particular among the poor and vulnerable groups; and improve the quality of health services for better health outcomes.[29] The Kenya Harmonized HBP also includes a number of service packages along six disease programmatic areas which are heavily funded by external donors.

Table 9: Summary of inclusion of services along six disease programmatic areas

Program	Colour code	Health benefits package (HBP)	Comment
Family Planning		Provision of family planning services e.g., commodities (*injectables, pills, IUCD, implants*), sterilization	
HIV		• HIV/AIDS Anti-Retroviral treatment and opportunistic infections treatment as this is provided for by the HIV program. Other outpatient and inpatient services are included. • Health promotion on prevention of communicable conditions • Sensitization of the community on safe sex practices • HIV test • Management in children	Not specified: laboratory services other than HIV test
Immunisation		Aligned with the Kenya Expanded Programme on Immunization, includes: OPV, Pentavalent, Rota virus, PCV 10, Measles and Other vaccinations (*namely yellow fever, HPV vaccination, Tetanus, Rabies*)	

[27] *NHIF (2021b), "NHIF SUPA Cover Products." National Hospital Insurance Fund. 2021.* ***http://www.nhif.or.ke/ healthinsurance/supacoverServices***

[28] *ThinkWell. 2019. "A Review of Makueni Care." Kenya Knowledge and Learning Brief 1. https://thinkwell.global/ wp-content/uploads/2020/02/Makueni-Care-Brief-2019_10_09-Final.pdf.*

[29] *Ministry of Health (2021), "Policy Brief on Universal Health Coverage Benefits Package 2020 DRAFT (Unpublished)."*

Program	Colour code	Health benefits package (HBP)	Comment
Malaria		Anti-malaria treatment as this is provided for by the malaria program. Other outpatient and inpatient services are included.	Not specified: public health interventions, prevention, laboratory services, second line treatments
MCH		• Maternal health: » Maternal Health Services » Maternal Nutrition » Pre-conception care » Focused antenatal care » Screening for reproductive health risks » Management of pregnancy complications » Management of abnormal pregnancies » Management of labour and delivery » Post-natal care and Maternal complications in the postpartum period e.g., post-partum haemorrhage, hypertensive disorders, puerperal sepsis Child health. • Management of common conditions in children e.g., diarrhoea, malaria, acute malnutrition, meningitis, upper and lower respiratory tract infections, ENT, skin, haematological, CNS, mental health and cardiovascular conditions. • Deworming and Micro-nutrient supplementation (e.g., vitamin A, IFA). • Managing children with special needs e.g., autism, abuse, neglect, disability	Has a 'negative list', e.g., modes of delivery reviewed for multiple deliveries
TB		Anti-tuberculosis treatment as this is provided for by the TB program. Other outpatient and inpatient services are included. Management in children.	Not specified details: prevention, laboratory services, second line treatments

Source: Ministry of Health (2021) and Y-Ling Chi and Lydia Regan (2021). Note: The entitlements listed in the harmonized package are classified where green signals a high level of inclusion (across the entire continuum of care) and Red signals a low level of inclusion (none or a handful of services only).

The NHIF and the Kenya Medical Supplies Authorities (KEMSA) are the main vehicles for implementing the UHC policy. The funding for the harmonized package delivery is expected to come from different sources for different types of services.

The NHIF is to reimburse curative and rehabilitative services provided in all contracted health facilities and hospitals; except for HIV, Tuberculosis, Malaria treatments (*including opportunistic infections in the case of HIV*) and vaccines, which will receive input financing from the Ministry of Health.[30] The Ministry of Health and the county governments are expected to be responsible for the provision of public and community services and to contribute to the UHC fund, which would pool resources from different sources including national and county governments, NHIF and partners.[31]

Following the enactment of the National Hospital Insurance (Amendment) Act, 2022, President Uhuru Kenyatta launched the national roll-out of Universal Healthcare Coverage (UHC) across the 47 counties on 7th February 2022 in Mombasa. With the national roll-out, the focus shifted further reforming the National Health Insurance Fund (NHIF); establishment of a mandatory Universal Health Coverage Scheme based on the harmonized package of health services, and provision of health insurance coverage for an initial 1 million low-income households to be biometrically registered.[32]

11.4 Issues and challenges in Universal Health Coverage implementation

The pilot UHC program in the four counties revealed the potential of achieving UHC goal of ensuring access to quality healthcare by all without discrimination. Notable successes included:- increased financial access to healthcare services in public facilities to residents who previously could not afford to pay for health services; increased health workforce; improved access to emergency and specialized health services; improved referral practices based on defined standard operating procedures and protocols; improved health outcomes especially for mothers and children; improved consistency in the supply of essential medicines; and improved infrastructure in health facilities leading upgrading of facilities to high levels of services and care.[33] However, the implementation of the UHC pilot program revealed several challenges some of which included exclusion of the vulnerable communities, inadequate information and awareness, inadequate resource allocation and envelop; delays in disbursement of funds; corruption; and lack of strategic and long-term view of the UHC pilot implementation. Summary of issues and challenges on implementation of UHC are summarized as follows:-

SUMMARY OF VIEWS/FINDINGS

1. **NHIF and UHC benefits package**
   a. Confusion over overlapping entitlements between current vertical programmes and the UHC-HBP in terms of how the inclusion of entitlements affects either their funding or delivery in practice, especially when those are covered by other disease programmes and HBPs. For example, the harmonized package lists services offered to expectants mothers (*pre-, during and post maternity*), which are also provided under the Linda Mama scheme. The management of HIV/AIDS, Malaria and TB is also covered by the new harmonized package, but that other costs (*e.g., medications*) [are] catered for by donors and the Government of Kenya.[34]
   b. Inadequate HBP design to effectively to serve targeted vulnerable populations or deliver needed services. The health benefits package is not explicit enough to state what would be purchased by the government and partners.

[30] *Ministry of Health (2021), "Policy Brief on Universal Health Coverage Benefits Package 2020 DRAFT (Unpublished)."*

[31] *Y-Ling Chi and Lydia Regan (2021), The Journey to Universal Health Coverage: How Kenya Managed the Inclusion of Disease Programmes in its Health Benefits Package, Centre for Global Development (CGD), Case Study, November 2021*

[32] *Mohamed Hassan 2022, Universal Healthcare Coverage Ready for Rollout, Kenya News Agency, Counties Editors Pick February 7, 2022*

[33] *People's Health Movement Kenya (2020), UHC Survey Dissemination report, DECEMBER 10, 2020*

[34] *Y-Ling Chi and Lydia Regan (2021), The Journey to Universal Health Coverage: How Kenya Managed the Inclusion of Disease Programmes in its Health Benefits Package, Centre for Global Development (CGD), Case Study, November 2021*

c. Inadequate and delayed NHIF reimbursement for services delivered at public facilities.

d. Rebate of some facilities remains lower than the level at which they operate. NHIF review of this needs to happen regularly.

e. Incremental/progressive approach to implementation of the UHC with no clear political commitment to full implementation and realization of the HBP for all.

f. Most people in the community are largely ignorant of NHIF and UHC-HBP until they require a medical service.

g. Large proportion of household eligible for household protection under HISP yet to be enrolled. Lack of clarity of modalities which hampers enrollment.

h. Lack of clear policy on Public-Private Partnership in delivery of UHC HBP

i. Lack of essential registration documents such as ID and birth certificates especially among the pastoral and rural communities. Alternative identification should be explored and considered.

2. UHC financing

a. Tight and inadequate budget envelope/allocation for the implementation of the full UHC-HBP leading to undue financial pressure in the provision of UHC to the population and hindering the chances of a full universal health coverage roll-out.

b. Disbursement modality from donors (*off-budget*) which limits the visibility on how the funds are used and their alignments with county and national plans and investments.

c. Delays in national government disbursement of equitable share and conditional grants to the counties and from the county revenue account funds to the health facilities

d. Delays in NHIF disbursement of capitation funds and payment processing of the monies in the County across all health units. This hampers the budgetary positions of the facilities limiting continuous care.

e. Inefficiencies and mismanagement of available funds allocated for healthcare services

f. Dependence on unpredictable, diminishing and unsustainable external funding for delivery of UHC and HBP

g. Inadequate costing of UHC-EBP to estimate the full resource requirements including the services in the disease programmatic areas heavily supported by donors (*HIV/AIDS, Malaria and TB*)

3. Access to quality of services

a. Lack of clear gender and social inclusion policy for children, people with disabilities, and Key Population/ MARPs. UHC was blind to GBV issues.

b. Lack of clear referral policy with patients having to pay out of pocket when referred to facilities out of the county as UHC was not being implemented in all counties for example cases where patients were referred to Kenyatta National Hospital

c. Inadequate infrastructure and facilities

d. Chronic shortage/stock outs of essential medicines, commodities and equipment leading to poor health service delivery

e. Limitations of KEMSA to supply products especially for critical conditions in time. Delays in dispatching KEMSA drugs or the drugs required or ordered not available.

4. **Health workforce**
   a. Inadequate and shortage of health workforce to effectively delivery quality healthcare services and respond to increased demand and influx of patients leading to staff being overwhelmed, long queues and waiting times. Increased workload but inadequate workforce.
   b. Poor health worker attitude and lack of respectful care
   c. Disruptive impact of frequent health workers' strikes
   d. Chronic delays or non-remittance of workers' deductions as required by the law denies employees especially within county public service from benefiting from their NHIF cover.

5. **Governance**
   a. Political economy of existing institutional structures associated with vertical programmes. Existing strong institutional structures supporting the delivery of the vertical disease programmatic areas, which would appear to make it complicated and difficult to make integration a reality
   b. Diversion of medical supplies and creating artificial shortages of drugs forcing patients to continue buying medicine from private pharmacies and institutions despite having registered for UHC thereby undermining the quality of healthcare services rendered.
   c. Political interference

6. **Health information system**
   a. Lack of feedback mechanism on the effectiveness of UHC
   b. Inadequate health education and communication at the community level
   c. Inadequate health management information systems and data unavailability. The ***M-TIBA*** data was not shared with the County for planning purposes.

11.5 Task force commentary

The UHC initiative presents an excellent opportunity to the County Government of Mombasa to accelerate the realization of the right of every person to the highest attainable standards of health and healthcare services and the full protection of the indigents and vulnerable individuals, families and populations from financial catastrophe or impoverishment associated with having to pay for the services. However, for UHC to succeed and be sustainable as envisioned, strong political commitment at all levels and a strong sense of urgency on transition from dependence external funding to innovative domestic financing are imperative.

While it is clear that the UHC's Harmonized HBP is intended to be a unifying policy across different levels of care and disease control priorities as is demonstrated by the wide range of entitlements,[35] the "***progressive***" approach to the implementation of the UHC; combination of different sources of UHC funding with heavy dependence unpredictable external funding to support delivery; and lack of clear responsibility assignment to county governments under the NHIF (*Amendment*) Act, 2022 for insuring the indigents and vulnerable, are likely to undermine the integration, sustainability and the full implementation and scale-up of the UHC HBP to the last mile.

[35] *Y-Ling Chi and Lydia Regan (2021), The Journey to Universal Health Coverage: How Kenya Managed the Inclu-sion of Disease Programmes in its Health Benefits Package, Centre for Global Development (CGD), Case Study, November 2021*

Taking a program rather than an integrated and comprehensive approach to UHC also risks piecemeal implementation that is likely to create tensions between the UHC programmes and the goals of ensuring access to comprehensive quality healthcare and improving health outcomes.

11.6 Recommendations

Universal Health Coverage (UHC) is about ensuring access to a full range and continuum of quality health services including promotive, preventive, curative, rehabilitative and palliative without financial hardship. To achieve this, the Task force recommends the development of an integrated and comprehensive Mombasa County UHC delivery strategy to be implemented through Mombasa Care program. To progressively enable all Mombasa residents to access affordable and quality health services, the recommendations contained herein reiterate the need to strengthen the health system in all dimensions and thus reflect and reinforce the recommendations already made under the other TOR areas of this report.

1. **Review and establish a sustainable framework for the efficient and effective delivery of universal health coverage health benefits package, leaving no behind:**
    a. Establish and implement the Mombasa Care program to enable all the residents especially the indigents and vulnerable individuals and families to access affordable and quality healthcare services based on the Kenya Harmonized HBP.
    b. Carry out a comprehensive county-wide mapping of all households under a digital demographic and surveillance system to identify the most vulnerable population through community health system for enrolment into NHIF and Mombasa Care
    c. Review the Kenya Harmonized HBP and develop an inclusive county context specific UHC-HB package including health, wellness and nutrition, mental health, drugs and substance abuse rehabilitation and SGBV services.
    d. Review and reform the Mombasa county health service delivery structure delivery of and access to affordable quality healthcare services for all without discrimination on any grounds
    e. Develop and implement Mombasa county NHIF and Mombasa Care enrolment and customer care/support model to support intentional enrolment of community members, especially women and girls and persons with disabilities into the Mombasa Care, NHIF and other existing health insurance schemes
    f. Develop and implement Mombasa County public and community health services package integrating preventive and promotive health services including public an environmental health services within the County UHC delivery framework. This will improve preventive and promotive primary care services to reduce the disease burden in Hospitals.
    g. Develop gender and social inclusion policies and guidelines for Mombasa Care to ensure equitable access to healthcare by all the indigents and vulnerable populations.
    h. Organize targeted Mombasa Care awareness raising campaigns
    i. Ensure timely remittance of NHIF deductions from all county employees for effective access of healthcare

2. **Strengthen the human resources for health capacity to deliver quality UHC HBP**
    a. Review the current establishment and increase the number of health workforce required to match the increased demand and workload especially in readiness for county UHC roll-out.
    b. Train health workers including CHVs to effectively support UHC roll-out and deliver facility and community based UHC package
    c. Provide customer care training to all health workers

3. **Strengthen the HPT supply chain management for effective delivery UHC HBP**
    a. Review the HPT supply chain system readiness and capacity to effectively deliver UHC HBP
    b. Review and renegotiate the partnership framework with Kenya Medical Supply Agency (KEMSA) to ensure reliable and timely supply of the required UHC BP HPTs
    c. Automate HPT supply chain management system to reduce wastage and improve efficiency and accountability.
    d. Align county HPT supply chain component with the Public Procurement and Disposal Act (PPDA) to ensure uninterrupted supply and resupply of HPTs
    e. Formulate the County Formula to guide the procurement and utilization of HPTs including micro-nutrients and supplements
    f. Establish County Centralized procurement for HPTUs and Oversight for levels 2s and 3s (*to guide the procurement that is done at source*).
    g. Enhance commodity security systems to reduce and control pilferage and wastage

4. **Improve the access to affordable and quality facility and community based UHC HBP and services**
    a. Carry out a comprehensive health facility readiness assessment for the implementation of the UHC HBP
    b. Develop County UHC policy and guidelines for health facilities
    c. Ensure adequate, well-equipped and optimally functioning public health facilities in line prescribed standards for UHC HBP and that all eligible county health facilities are NHIF compliant
    d. Strengthen the PHC system
    e. Strengthen framework for inter-county collaboration in UHC among neighbouring countries
    f. Review and harmonize standards of care at the various levels of care
    g. Establish UHC centres of excellence and specialty service centres e.g. cancer, diabetes, mental health, SGBV etc.
    h. Enhance provision of and access to comprehensive SRH services including adolescent friendly facilities, training programme for adolescents, teachers and care-givers on adolescent related health issues
    i. Establish centrally managed emergency transport system and command centre and provide special maternal, perinatal and neo-natal referral services to reduce child and maternal mortality
    j. Establish community based call centres within health facility neighbourhoods/catchment areas to facilitate rapid and timely emergency response

5. **Ensuring sustainable and adequate UHC Financing**
    a. Establish sustainable strategies for financing UHC roll-out. Initiate Public/Private partnership in financing health services within the County.
    b. Ring-fence health generated revenue to ensure visibility and sustainably of our healthcare facilities
    c. Increase County health budget to support UHC roll-out.
6. **Strengthening UHC M&E framework and accountability**
    a. Develop a robust UHC monitoring and evaluation framework.
    b. Institute effective feedback and complaints reporting mechanisms
    c. Establish County UHC knowledge management platform to promote knowledge exchange and networking
    d. Leverage the use of data to ensure that the vulnerable access healthcare services without incurring out of pocket extra costs.
    e. Strengthen mechanisms of regular reviews and analyses to assess progress and performance against County UHC strategy priorities, indicators and targets
7. **Enhancing citizen participation in UHC governance**
    a. Review the organizational capacity and health system readiness for UHC roll-out
    b. Organize and hold extensive consultations with the health sector fraternity on Mombasa Care and UHC program
    c. Review county policy and legal framework for the implementation of the UHC program.
    d. Promote citizen and community participation in UHC role out and social audits of the UHC implementation and performance
    e. Sensitize members of the public on what UHC is, how it works, and what costs and benefits are associated with it.

12.1 Conclusion

The Task force in exercise of her mandate, listened carefully to the views of Mombasa County residents and stakeholders and their desire for a well-functioning county health system delivering quality healthcare services to all.

Majority of Mombasa County residents and stakeholders were critical of the quality of healthcare provided in public health facilities due to myriad challenges including inadequate and poorly equipped and maintained health facilities and infrastructure; inadequate and demotivated health workforce; poor work environment; inadequate and unreliable supply of quality health products and technologies; inadequate health financing, lack of social protection mechanisms for the indigents and the vulnerable; fragmented and inadequate health management information systems; and weak governance, leadership and regulatory system among others.

The Task force therefore recommends a fundamental reform of the county health system and service delivery model. To protect individuals and families from the catastrophic medical expenses and ensure financial access to essential public health services, the Task force recommends the establishment of a Mombasa Care Initiative.

12.2 Way Forward

The Task force recognizes His Excellency the Governor and his Government's commitment to implement the recommendations contained in this report. To further crystallize the recommendations, the Task force recommends the following next steps:

1. The Secretariat immediately develops a costed Task force Recommendations implementation road-map and plan;
2. His Excellency establishes the Mombasa County Health Reforms Advisory Technical Committee;
3. The County Health Department with the support of the Governor's Office hold dissemination forums for the County and Sub County Health Management Teams and Health facility management Teams and other stakeholders on the recommendations and implementation road-map and plan;
4. Integrate Task force Report and recommendations into the third generation County Integrated Development Plan (CIDP); Health Sector Strategic and Investment Plan; and the Annual Development Plan and Budget 2022/2023 (*through supplementary budget)* for priority interventions and ADP and Budget 2023/2024; and
5. Immediate review of the Mombasa County Health Act to integrate the key recommendations that require legislative intervention.

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